Office-Supreme Court, U.S.
FILED
JUN 15 1981
ALEXANDER L. STEVAS,
CLERK

No. 80-419

IN THE

Supreme Court of the United States

OCTOBER TERM, 1980

STATE OF ARIZONA,
Petitioner,

vs.

MARICOPA COUNTY MEDICAL SOCIETY,
MARICOPA FOUNDATION FOR MEDICAL CARE, and
Pima Foundation For Medical Care,
Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

JOINT APPENDIX

Vol. 1 Pages 1-274

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PETITION FOR CERTIORARI FILED SEPTEMBER 16, 1980
CERTIORARI GRANTED MARCH 9, 1981

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INDEX

	Page
Chronological List of Relevant Docket Entries	viii
Antitrust Complaint and Demand for Jury Trial, Filed October 17, 1978 (CR 1)*	1
Order [U.S. District Court], filed November 2, 1978 (CR 18)	13
Answer of Defendant Pima Foundation for Medical Care, Filed November 15, 1978 (CR 20)	15
Defendant Maricopa Foundation for Medical Care's Motion to Dismiss the Complaint, Filed November 17, 1978 (CR 25)	17

---

*References are to the Clerk's Record designated in the Ninth Circuit Court of Appeals.

Page

Memorandum in Support of Defendant Maricopa Foundation for Medical Care's Motion to Dismiss the Complaint, Filed November 17, 1978 18

Affidavit of Anthony D. Mitten 31

Deposition of Mary Gerdonics, Filed November 20, 1978 (CR 27) 34

Plaintiff's Motion for Partial Summary Judgment on the Issue of Liability and Notice of Hearing, Filed November 20, 1978 (CR 30) 40

Memorandum in Support of Plaintiff's Motion for Partial Summary Judgment on the Issue of Liability, Filed November 20, 1978 (CR 30) 41

Response to Plaintiff's Motion for Partial Summary Judgment on the Issue of Liability [Pima Foundation], Filed December 7, 1978 (CR 39) 53

Opposition to Plaintiff's Motion for Partial Summary Judgment on the Issue of Subject Matter Jurisdiction, Filed December 7, 1978 (CR 40) 54

Exhibit "A": omitted in printing 73

Exhibit "B": Affidavit of Thomas P. Finley 74

Response of Defendant Maricopa County Medical Society to Plaintiff's Motion for Partial Summary Judgment on the Issue of Liability, Filed December 11, 1978 (CR 49) 80

Defendant Maricopa County Medical Society's Response to Plaintiff's Statement of Undisputed Material Facts on its Motion for Partial Summary Judgment on the Issue of Liability, Filed December 11, 1978 (CR 50) 81

Page

Defendant Maricopa Foundation for Medical Care's Statement of Material Facts as to which there is a Genuine Issue Precluding Partial Summary Judgment in Favor of Plaintiff on the Issue of Subject Matter Jurisdiction, Filed December 12, 1978 (CR 53) 82

Affidavit of Anthony D. Mitten 88

Affidavit of Gary L. Swingle 92

Exhibit A: Medical Fee Schedule adopted by the Industrial Commission of Arizona 95

Defendant Maricopa Foundation for Medical Care's Statement of Material Facts as to which there is a Genuine Issue Precluding Summary Judgment in Favor of Plaintiff on the Issue of Liability, Filed December 12, 1978 (CR 54) 123

Maricopa Foundation for Medical Care's Memorandum in Opposition to Plaintiff's Motion for Partial Summary Judgment on the Issue of Liability Filed December 12, 1979 (CR 55) 136

Statement of Undisputed Facts Supporting Plaintiff's Motion for Partial Summary Judgment on the Issue of Liability with Supplemental References, Filed December 21, 1978 (CR 66) 144

Exhibit A: Response of Defendant Pima Foundation for Medical Care to Plaintiff's First Request for Admissions and Interrogatories 156

Exhibit B: Plaintiff's First Request for Admissions and Interrogatories and Responses of Defendant Maricopa Foundation for Medical Care 189

Exhibit C: Defendant Maricopa County Medical Society's Responses to Plaintiff's First Request for Admissions and Interrogatories 272

Page

Exhibit D: [Attorney Correspondence and Stipulations with Respect to Exhibits], (contents omitted in printing) 274

Exhibit E: Maricopa Foundation for Medical Care 1970 [containing California Relative Value Studies], (contents omitted in printing) 274

Exhibit F: Radiology Relative Values, (contents omitted in printing) 274

Exhibit G: American Society of Anesthesiologists, Relative Value Guide 1973, (contents omitted in printing) 274

Exhibit H: California Relative Value Schedule Conversion Manual 1977 - 1969 - 1964, (contents omitted in printing) 274

Exhibit I: Maricopa Foundation for Medical Care Conversion Factors for all New or Renewed Groups after December 1, 1977, (contents omitted in printing) 274

Exhibit J: Letter from Lawrence J. Shapiro, President of the Maricopa Foundation for Medical Care, dated September 30, 1977, to all Foundation doctors together with a ballot for the approval or disapproval of new conversion factors . 275

Exhibit K: Minutes of the Maricopa Foundation for Medical Care Board of Trustees, dated October 17, 1977, reporting on the fee schedule ballot 277

Exhibit L: Pima Foundation for Medical Care, Maximum Fee Schedule for Preventative Child Care 279

Exhibit M: Minutes, Maricopa Foundation for Medical Care Fee Reimbursement Committee, dated May 22, 1978 280

Page

Exhibit N: By-Laws of Pima Foundation for Medical Care 281

Deposition of Anthony D. Mitten (Vol. I), Filed December 22, 1978 (CR 69) 297

Deposition of Anthony D. Mitten (Vol. II), Filed December 22, 1978 (CR 71) 305

Affidavit of Anthony D. Mitten, Filed April 19, 1979 309

Order [U.S. District Court], Filed April 30, 1979 (CR 98) 312

Separate Answer of Maricopa County Medical Society to Complaint, Filed June 15, 1979 (CR 100) .. 313

Answer of Defendant Maricopa Foundation for Medical Care, Filed June 15, 1979 (CR 101) 318

Motion of Defendant Maricopa Foundation for Medical Care to Vacate Temporary Restraining Order of April 30, 1979 and Notice of Submission without a Hearing, Filed June 27, 1979 (CR 103) .. 322

Memorandum in Support of Defendant Maricopa Foundation for Medical Care's Motion to Vacate Temporary Restraining Order of April 30, 1979, Filed June 27, 1979 (CR 103) 323

Affidavit of Anthony D. Mitten 332

Motion of Defendant Pima Foundation for Medical Care to Vacate Temporary Restraining Order of April 30, 1979, and Notice of Submission without a Hearing, Filed June 29, 1979 (CR 104) 334

Affidavit of Thomas P. Finley 335

Memorandum and Order [U.S. District Court], Filed July 11, 1979 (CR 111) 337

Plaintiff's Motion for Summary Judgment and Permanent Injunction, Filed July 6, 1979 (CR 105) 339

Page

Memorandum in Support of Plaintiff's Motion for Summary Judgment and Permanent Injunction, Filed July 6, 1979 (CR 105) 340

Statement of Undisputed Facts Supporting Plaintiff's Motion for Summary Judgment and Permanent Injunction, Filed July 6, 1979 (CR 106) 377

Exhibit A: Articles of Incorporation of the Arizona Medical Association, Inc. 397

Exhibit C: Agreement Containing Consent Order to Cease and Desist, *In the Matter of California Medical Association* 404

Exhibit D: Agreement Containing Consent Order to Cease and Desist, *In the Matter of the American College of Radiology* 404

Exhibit E: Affidavit of Alice McLain (with attachments) 404

Exhibit F: omitted in printing 427

Plaintiff's Motion for Reconsideration of Memorandum and Order of June 5, 1979, or, Alternatively, Motion for Certification for Interlocutory Appeal Pursuant to 28 U.S.C. § 1292(b) of Memorandum and Order of June 5, 1979, Filed July 6, 1979 (CR 107) 428

Memorandum of Points and Authorities (CR 107) . 429

Supplemental Response of the State of Arizona to Defendant Maricopa Foundation for Medical Care's First Set of Interrogatories, verified July 13, 1979 471

Memorandum and Order [U.S. District Court], Filed July 18, 1979 (CR 111) 480

Notice of Appeal, Filed July 19, 1979 (CR 112) 482

Page

Defendant Maricopa Foundation for Medical Care's Response to Plaintiff's Motion for Summary Judgment and Permanent Injunction, Filed July 23, 1979 (CR 116) 483

Defendant Maricopa Foundation for Medical Care's Memorandum in Opposition to Plaintiff's Motion for Reconsideration of Memorandum and Order of June 5, 1979, Filed July 23, 1979 (CR 117) 502

Defendant Maricopa Foundation for Medical Care's Statement of Material Facts as to Which There is a Genuine Dispute Precluding Summary Judgment in Favor of the Plaintiff, Filed July 31, 1979 (CR 122) 511

Emergency Motion of Appellees Maricopa Foundation for Medical Care and Pima Foundation for Medical Care to Vacate Injunction and Dismiss Appeal and for Expedited Hearing and Accelerated Briefing, Filed August 22, 1979 527

Affidavit of Lawrence Shapiro 529

Affidavit of Anthony D. Mitten 532

Affidavit of Thomas P. Finley 535

Affidavit of Arthur Dudley, Jr. 538

Order of Court of Appeals (affirming district court), Filed November 19, 1979 ..... Pet. App. A36

Opinion of Court of Appeals, Filed March 20, 1980 ..... Pet. App. A1

Order of Court of Appeals, Filed April 28, 1980 (supplementing the Opinion) ..... Pet. App. A33

Order [Ninth Circuit Court of Appeals], Filed May 30, 1980 541

Order [Ninth Circuit Court of Appeals], Filed June 18, 1980 541

CHRONOLOGICAL LIST OF RELEVANT DOCKET ENTRIES

October 17, 1978—Antitrust Complaint and Demand for Jury Trial (CIV. 78-800 PHX WPC)

November 15, 1978—Answer of Defendant Pima Foundation for Medical Care

November 17, 1978—Judgment (Pima County Medical Society)

November 20, 1978—Plaintiff's Motion for Partial Summary Judgment on the Issue of Liability and Notice of Hearing

November 20, 1978—Memorandum in Support of Plaintiff's Motion for Partial Summary Judgment on the Issue of Liability

December 7, 1978—Defendant Pima Foundation's Response to Plaintiff's Motion for Partial Summary Judgment on the Issue of Liability

December 11, 1978—Response of Defendant Maricopa County Medical Society to Plaintiff's Motion for Partial Summary Judgment on the Issue of Liability

December 11, 1978—Defendant Maricopa County Medical Society's Response to Plaintiff's Statement of Undisputed Material Facts on its Motion for Partial Summary Judgment on the Issue of Liability

December 12, 1978—Defendant Maricopa Foundation for Medical Care's Statement of Material Facts as to Which There is a Genuine Issue Precluding Summary Judgment in Favor of the Plaintiff on the Issue of Liability

December 12, 1978—Defendant Maricopa Foundation's Memorandum in Opposition to Plaintiff's Motion for Partial Summary Judgment on the Issue of Liability

December 12, 1978—Affidavit of Anthony D. Mitten

December 21, 1978—Reply Memorandum in Support of Plaintiff's Motion for Partial Summary Judgment on the Issue of Liability

December 21, 1978—Statement of Undisputed Facts Supporting Plaintiff's Motion for Partial Summary Judgment on the Issue of Liability with Supplemental References
Exhibits are attached separately (A-N)

July 6, 1979—Plaintiff's Motion for Reconsideration of Memorandum and Order of June 5, 1979, or, Alternatively, Motion for Certification for Interlocutory Appeal Pursuant to 28 U.S.C. §1292(b) of Memorandum and Order

July 17, 1979—Notice of Appeal—from the Order granting defendants' motion to vacate the April 30, 1979 temporary restraining order

August 6, 1979—Minute Entry: Motion for Reconsideration denied; Motion for Summary Judgment [under rule of reason] denied; interlocutory appeal granted

August 8, 1979—Certificate and Order that the Order entered June 5, 1979 is amended and is certified for interlocutory appeal

August 8, 1979—Order Staying Proceedings pending the final determination of the Court of Appeals with respect to the interlocutory appeal

November 19, 1979—Order of the Court of Appeals for the Ninth Circuit

March 20, 1980—Opinion of the United States Court of Appeals for the Ninth Circuit

April 28, 1980—Order of the United States Court of Appeals for the Ninth Circuit [Modifying the Opinion]

June 18, 1980—Order of the Court of Appeals for the Ninth Circuit [Denying Petition for Rehearing and Suggestion of Appropriateness of Rehearing In Banc]

Filed - OCT 17, 1978
W. J. Furstenau, Clerk
U. S. District Court
For The District of Arizona

IN THE UNITED STATES DISTRICT COURT FOR THE DISTRICT OF ARIZONA

STATE OF ARIZONA, *Plaintiff,* vs. MARICOPA COUNTY MEDICAL SOCIETY, an Arizona non-profit corporation; MARICOPA FOUNDATION FOR MEDICAL CARE, an Arizona non-profit corporation; PIMA COUNTY MEDICAL SOCIETY, an Arizona non-profit corporation; and PIMA FOUNDATION FOR MEDICAL CARE, an Arizona non-profit corporation, *Defendants.*	NO. CIV. 78-800 PHX WPC ANTITRUST COMPLAINT AND DEMAND FOR JURY TRIAL

The STATE OF ARIZONA, on its own behalf and as *parens patriae* on behalf of the citizens of the State of Arizona, brings this action for injunctive and declaratory relief and alleges as follows:

COUNT ONE

I

JURISDICTION AND VENUE

1. Count One of this Complaint is brought and the jurisdiction of this Court is invoked under 28 U.S.C. §§ 1331 and 1337 and Section 16 of the Clayton Act, 15 U.S.C. § 26, for injunctive and declaratory relief against the defendants' continuing violations of Section 1 of the Sherman Act, 15 U.S.C. § 1.

2. The claims for relief set forth in Counts One and Two of this Complaint are derived from a common nucleus of operative facts involving substantially identical issues of fact and law. The entire action constitutes a single case which ordinarily would be tried in one judicial proceeding. For the interests of judicial economy, covenience and fairness and in order to avoid unnecessary duplication and multiplicity of actions, this Court's jurisdiction over Count Two is pendent to this Court's jurisdiction over Count One.

3. Venue as to each defendant is laid in this judicial district pursuant to 28 U.S.C. §§ 1391(b) and (c) and Section 12 of the Clayton Act, 15 U.S.C. § 22. Each of the defendants is incorporated, maintains an office, and transacts business within the District of Arizona. The claims for relief alleged herein arose within the District of Arizona. Each of the defendants, together with its members, is within the jurisdiction of this Court.

4. The interstate trade and commerce described herein is conducted into, within and from the District of Arizona. The acts complained of herein are within the flow of interstate trade and commerce and have a direct and substantial effect on that trade and commerce.

II
DEFINITIONS

5. As used herein:

(a) "Doctor" means a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.) or Doctor of Podiatry (D.P.M.) who is duly licensed to practice in the State of Arizona.

(b) "Doctor's service" means any medical, surgical or other health care procedure or service performed by a doctor or person working under the supervision of a doctor in return for a price based on that procedure or service.

(c) "Relative value schedule" means a list or compilation of doctor's services which sets comparative unit values for those services.

(d) "Unit conversion factor" means a number or dollar figure used to multiply the unit value for any doctor's service into a dollar figure payable for that service.

(e) "Health insurance" means a system of protection in which periodic payments (premiums) are made to an insurer in return for that insurer's underwriting the risk of certain medical costs that may be incurred by the policyholder.

(f) "Foundation Plan" means a health insurance plan endorsed by Defendant Maricopa Foundation for Medical Care or Defendant Pima Foundation for Medical Care.

(g) "Foundation policyholder" means any person whose medical expenses are insured in whole or part through a Foundation Plan, whether or not that person pays the premium for such insurance.

(h) "Foundation member" means any participating or cooperating member of Defendant Maricopa Foundation for Medical Care or Defendant Pima Foundation for Medical Care.

(i) "Foundation subscriber" means any individual, group, employer or governmental entity that paid all or part of the premium for any Foundation plan.

III
PLAINTIFF

6. Plaintiff, the State of Arizona, brings this action on its own behalf and as *parens patriae* on behalf of the citizens of the State of Arizona.

7. The State of Arizona and its citizens purchase substantial amounts of doctors' services and health insurance and have been and continue to be injured by the violations of the antitrust laws alleged herein. In 1977 the State of Arizona alone paid $7,615,536 for health insurance premiums. The State of Arizona has also paid substantial sums directly to doctors for services, goods and equipment.

IV
DEFENDANTS

8. Each of the corporations named below is made a defendant herein.

(a) The Maricopa County Medical Society (hereinafter the "Maricopa Society") is an Arizona non-profit corporation with its principal place of business in Phoenix, Arizona. The Maricopa Society is an association of licensed practitioners of medicine or surgery in Maricopa County, Arizona.

(b) The Maricopa Foundation for Medical Care (hereinafter the "Maricopa Foundation") is an Arizona non-profit corporation with its principal place of business in Phoenix, Arizona. The Maricopa Foundation is an association of doctors having four classes of members. Its "administrative members" are the members of the Board of Directors of the Maricopa Society. Its "participating members" are doctors who are qualified to be or are active members of the Maricopa Society or another county medical society in the State of Arizona or the Arizona Osteopathic Society. Its "cooperating members" are members of the Arizona Podiatry Society or the Arizona Society of Oral Surgeons. Its "PSRO members" are providers of doctor's services to Federal Medicare patients. The Maricopa Foundation is controlled by the Maricopa Society. The Executive Director of the Maricopa Society is also the Executive Director of the Maricopa Foundation. Over 70 percent of the doctors practicing in Maricopa County are participating or cooperating members of the Maricopa Foundation having a right to vote on the adoption of uniform, average or median fee schedules.

(c) The Pima County Medical Society (hereinafter the "Pima Society") is an Arizona non-profit corporation with its principal place of business in Tucson, Arizona. The Pima Society is an association of licensed practitioners of medicine or surgery in Pima County, Arizona.

(d) The Pima Foundation for Medical Care (hereinafter the "Pima Foundation") is an Arizona non-profit corporation with its principal place of business in Tucson, Arizona. The Pima Foundation is an association of doctors having four classes of members. Its "administrative members" are the members of the Board of Directors of the Pima Society. Its "participating members" are doctors who are qualified to be or are members of the Pima Society or the county medical society in any county contiguous to Pima County, Arizona. Its "cooperating members" are members of the Arizona Osteopathic Society or the Arizona Podiatry Society who reside in Pima County or in any county contiguous to Pima County, Arizona. Its "PSRO members" are providers of doctor's services to Federal Medicare patients. The Pima Foundation is controlled by the Pima Society. Over 70 percent of the doctors practicing in Pima County are participating or cooperating members of the Pima Foundation having a right to vote on the adoption of uniform fee schedules.

V

CO-CONSPIRATORS

9. Various individuals, partnerships, corporations and associations not named as defendants herein have participated as co-conspirators in the violations alleged herein and have performed acts and made statements in furtherance of those violations. Such co-conspirators include, without limitation, individual members, officers, directors, trustees and employees of each of the defendants; various doctors' associations and individual members and officers of those associations; and various individuals and corporations engaged in selling and underwriting health insurance in the State of Arizona.

VI
NATURE OF TRADE AND COMMERCE

10. Health care is a substantial industry in the United States and in the State of Arizona. In 1976, national health care expenditures totalled approximately $140 billion, while health care expenditures in the State of Arizona totalled approximately $1.3 billion. Health care costs have been increasing at a substantially greater rate than costs in other sectors of the economy. The disproportionate increase in health care costs has caused significant displacement in the economy of Arizona. In 1971 health care expenditures accounted for 7.4 per cent of Arizona's gross state product and 7.6 per cent of the gross national product; by 1976 health care expenditures accounted for 10.4 per cent of Arizona's gross state product, compared to 8.7 per cent of the gross national product. Between 1974 and 1976, the increase in health care expenditures in Arizona was 357 per cent greater than the increase in Arizona's gross state product.

11. There are approximately 3,750 doctors engaged in the practice of medicine in the State of Arizona; approximately 60 percent of those doctors are members of the Maricopa Society or Pima Society. During the period from 1966 to 1975, payments to doctors in the State of Arizona nearly tripled, climbing from approximately $75,867,000 in 1966 to approximately $218,379,000 in 1975. Doctors in Arizona receive and treat patients from other states, refer Arizona patients for treatment out-of-state, receive substantial sums of money which flow across state lines for medical services rendered in Arizona, and prescribe medicines and other goods and products which are shipped in interstate commerce and form an integral part of the interstate distribution of such prescription drugs, goods and products.

The practice of medicine involves the purchase, use and sale of goods and products which are manufactured and sold and flow in a continuous and uninterrupted stream of interstate commerce.

12. A substantial portion of the prices charged by doctors to patients are paid through health insurance. The State of Arizona and many of its citizens purchase health insurance and the premiums paid for such health insurance total approximately $350 million annually in the State of Arizona. The prices doctors charge for their services, goods and products have a direct and substantial effect upon payments made to and premiums charged by insurers. Health insurance involves a continuous and uninterrupted flow of services, products, contracts and claims in interstate commerce and the transfer of substantial sums of money across state lines.

13. Defendants Maricopa Foundation and Pima Foundation endorse certain health insurance plans (hereinafter referred to as "Foundation Plans") which are underwritten by private insurers in the State of Arizona and elsewhere and meet certain "minimum standards" formulated by defendants. Those minimum standards include, among other things, coverage of a wide range of services, goods and equipment sold by doctors. Defendants and their co-conspirators set the prices which the insurers must pay under Foundation Plans for covered services, goods and products sold by doctors to Foundation policyholders. Foundation Plans involve a substantial and uninterrupted flow of products, services, contracts and claims in interstate commerce and the transfer of substantial sums of money across state lines.

VII
VIOLATIONS ALLEGED

14. Beginning at a time unknown to plaintiff but believed to be on or about December 22, 1969, and continuing thereafter up to and including the filing of this Complaint, defendants and their co-conspirators have engaged in a con-

tinuing combination and conspiracy in unreasonable restraint of the aforesaid interstate trade and commerce in violation of Section 1 of the Sherman Act, 15 U.S.C. § 1. Plaintiff is informed and believes that said combination and conspiracy is continuing and may continue in the future unless the relief herein prayed for is granted.

15. The aforesaid combination and conspiracy consists of a continuing agreement, understanding and concert of action among the defendants and their co-conspirators, the substantial terms of which have been, among others:

(a) to fix, raise, maintain and stabilize prices charged by doctors;

(b) to establish and maintain uniform and agreed-upon systems for determining prices charged by doctors;

(c) to establish, maintain and revise uniform and agreed-upon relative value schedules;

(d) to fix, raise, maintain and stabilize unit conversion factors to be used in connection with the aforementioned relative value schedules;

(e) to control and restrain third party review of prices charged by doctors; and

(f) to reduce and eliminate price competition among doctors.

16. In formulating and effectuating the aforesaid combination and conspiracy, defendants and their co-conspirators did those things which they combined and conspired to do including, among other things:

(a) consulted with and surveyed doctors and doctors' associations with respect to current and desired prices for services, goods and products sold by doctors;

(b) consulted with and surveyed doctors and doctors' associations with respect to relative value schedules, unit conversion factors and other fee schedules used to determine prices for services, goods and products sold by doctors;

(c) prepared, adopted, maintained and published schedules of agreed-upon prices for services, goods and products sold by doctors;

(d) compiled, revised, maintained and published relative value schedules;

(e) compiled, revised, maintained and published schedules of unit conversion factors for use with relative value schedules;

(f) prepared, approved and published changes in relative value schedules, unit conversion factors and fee schedules after surveying and consulting with doctors and doctors' associations with respect to such changes;

(g) adhered to Foundation relative value schedules, unit conversion factors and fee schedules;

(h) entered into agreements with health insurers that the insurers pay for covered services, goods and products sold to Foundation policyholders by doctors at prices set by defendants and their co-conspirators;

(i) required as a term of membership in the Maricopa Foundation or Pima Foundation that Foundation members accept payment on assigned claims for services, goods and products sold to Foundation policyholders in accordance with Foundation fee schedules;

(j) gave advance notice of planned increases in Foundation fee schedules to health insurers so that the resulting increases in prices charged by doctors were passed on to Foundation subscribers through increased health insurance premiums;

(k) controlled the review and administration of claims for services, goods and products sold by doctors to Foundation policyholders.

VIII
EFFECTS OF THE CONSPIRACY

17. The aforesaid combination and conspiracy has had the following effects, among others:

(a) schedules of agreed-upon prices for services, goods and products sold by doctors have been regularly published to the majority of doctors in the State of Arizona;

(b) Foundation fee schedules have set an agreed-upon level for prices charged by doctors;

(c) prices for services, goods and products sold by doctors have been fixed, maintained and stabilized at artificial and non-competitive levels;

(d) prices for services, goods and products sold by doctors have been raised collectively to agreed-upon levels;

(e) uniform systems for setting the prices of services, goods and products sold by doctors have been established, maintained and stabilized;

(f) price competition in the sale of services, goods and products sold by doctors has been restricted, suppressed and restrained;

(g) purchasers of the services, goods and products sold by doctors have been deprived of the benefits of free and open competition and the right to obtain such services, goods and products at competitively determined prices;

(h) review by third party payors of the prices charged for doctors' services, goods and products has been restricted, suppressed and restrained;

(i) The cost of health insurance has been increased.

COUNT TWO

IX

18. Plaintiff repeats and realleges the allegations contained in Paragraphs 1 through 17 as if again set forth in full.

19. The aforementioned conduct of the defendants and co-conspirators violates Arizona Revised Statutes Annotated §§ 44-1401, *et seq.*, commonly known as the Uniform State Antitrust Act.

X

WHEREFORE, Plaintiff prays:

1. That the Court adjudge and decree that the aforesaid combination and conspiracy and the acts done in pursuance thereof were and are an unreasonable restraint of trade and commerce in violation of Section 1 of the Sherman Act, 15 U.S.C. § 1, and Arizona Revised Statutes Annotated § 44-1402.

2. That pursuant to Section 16 of the Clayton Act, 15 U.S.C. § 26, and Arizona Revised Statutes Annotated § 44-1408(B) the defendants and their members be permanently enjoined from continuing the violations of the law alleged in this Complaint and from entering into any combination, conspiracy, agreement, understanding or concert of action having a similar purpose or effect.

3. That pursuant to Section 16 of the Clayton Act, 15 U.S.C. § 26, and Arizona Revised Statutes Annotated § 44-1408(B) the Court enter such decree as may be required to restore competition in the sale of services, goods and products by doctors.

4. That defendants be required to distribute to each of their members a copy of the final judgment or decree entered by this Court within 60 days after entry of such judgment or decree.

5. That defendants' members be required to surrender to plaintiff within 120 days after the date of entry of the final judgment or decree all relative value schedules, schedules of unit conversion factors, other fee schedules and minimum standards for health insurance and all copies thereof in their possession.

6. That plaintiff recover from defendants the costs of this suit including a reasonable attorney's fee in accordance with Sections 4 and 16 of the Clayton Act, 15 U.S.C. §§ 15, 26, and Arizona Revised Statutes Annotated § 44-1408(B).

7. That plaintiff have such other, further or different relief as the law may require or the Court may deem just and proper.

(Signature omitted in printing.)

JURY DEMAND

PLEASE TAKE NOTICE that plaintiff demands a trial by jury pursuant to Rule 38(b), Federal Rules of Civil Procedure, of all issues triable of right by a jury.

(Signature omitted in printing.)

Filed - NOV. 2, 1978
W. J. Furstenau, Clerk
U. S. District Court
For The District of Arizona

(Caption omitted in printing.)

ORDER

Pursuant to stipulation of the parties,

IT IS ORDERED that:

1. On or before November 17, 1978, defendants shall file and serve motions permitted under Rule 12, Federal Rules of Civil Procedure, or answers to the complaint herein. Plaintiff will file and serve its response to all Rule 12 motions filed by defendants on or before November 27, 1978 and defendants will file and serve their reply papers on or before December 4, 1978. All such motions will be set for hearing on December 11, 1978, at 10:00 a.m.

2. Defendants shall file and serve their responses to plaintiff's First Request for Admissions and Interrogatories on Rule 42C within one week following the meeting of counsel pursuant to Local Rule 42A. The Court shall then set a pre-hearing conference pursuant to Local Rule 42D and a date for hearing plaintiff's motion for preliminary injunction which will be as soon after the pre-hearing conference as possible and prior to April 30, 1979.

6. For the purpose of maintaining the status quo until plaintiff's preliminary injunction motion may be heard, until the earlier of May 1, 1979, or final judgment for any party in this action, or further order of this Court, no defendant, nor any officer, agent, servant, employee or attorney of any defendant nor any person in active concert or participation with any defendant who receives actual notice of this order by personal service or otherwise shall participate in any survey, agreement, vote or other step to

establish, determine or disseminate any relative value or conversion factor with respect to medical services, goods or products other than those relative values and conversion factors in effect on or before October 18, 1978.

DONE IN OPEN COURT this 2 day of November, 1978.

/s/

Honorable Willie [illegible]. Copple,
Judge, United States District Court

Filed - NOV. 15, 1978
W. J. Furstenau, Clerk
U. S. District Court
For The District of Arizona

ANSWER OF DEFENDANT PIMA FOUNDATION FOR MEDICAL CARE

The defendant, Pima Foundation for Medical Care, an Arizona non-profit corporation, answers the Complaint as follows:

COUNT ONE

I

While it admits that the plaintiff claims the jurisdiction of this Court under the statute recited in Paragraph 1 of the Complaint, it denies that in fact this Court has jurisdiction over it in this matter.

II

It denies that it is engaged in interstate commerce, either within or from the District of Arizona, or that any of its acts are within the flow of interstate trade and commerce or have any direct or substantial effect on such trade or commerce.

III

It denies the status of the State of Arizona to bring this action and it denies further that the State or its citizens purchased "substantial amounts of doctors' services and health insurance" which is affected in any way by the activities of this defendant.

IV

It admits the allegations of Paragraph IV referable to it except that it specifically denies that it has four classes of members, affirmatively alleging that it has in fact three classes of members and that it has no "PSRO members" at

all; and it further denies that over 70% of the doctors practicing in Pima County are participating or cooperating members of the Foundation or have anything whatever to do with the Foundation or its structure.

V

It denies the allegations of Paragraph V.

VI

It admits that health care is a substantial industry in the United States and in the State of Arizona, and it has no information sufficient to enable it to form any belief as to the truth of the allegations of Paragraph VI(10), and hence denies them all; it admits the allegations of the first sentence of Paragraph VI(11); and it has no information sufficient to enable it to form any belief as to the truth of the allegations of the remainder of (11) and hence denies them all.

VII

It denies that health insurance, to the extent that it is in any way applicable to the activities or structure of this defendant, involves a continuous and uninterrupted flow of services, products, contracts and claims in interstate commerce or the transfer of substantial sums of money across state lines, and otherwise admits the allegations of Paragraph VI(12).

VIII

It denies that it and others set the prices which insurers must pay under Foundation plans for covered services, goods and products sold by doctors to Foundation policyholders; it denies further that its plan or it itself involves a substantial and uninterrupted flow of products, services, contracts and claims in interstate commerce and the transfer of substantial sums of money across state lines; and it admits the remaining allegations of Paragraph VI(13).

IX

It denies every allegation of Paragraph VII in all its parts, and all of the allegations of Paragraph VIII in all its parts, and every other allegation of the Complaint, including all the allegations of Count Two not specifically admitted when included in Count One.

AFFIRMATIVE DEFENSES

I

As a further and alternative defense, this defendant avers that the Court is without jurisdiction over the subject matter of the Complaint against this defendant in this case.

WHEREFORE, this defendant prays for judgment in its favor on the Complaint, for its costs herein incurred, and for all other appropriate relief.

(Signature omitted in printing)

Filed - NOV. 17, 1978
W. J. Furstenau, Clerk
U. S. District Court
For The District of Arizona

(Caption omitted in printing.)

DEFENDANT MARICOPA FOUNDATION FOR MEDICAL CARE'S MOTION TO DISMISS THE COMPLAINT

Defendant Maricopa Foundation for Medical Care, moves the Court pursuant to Rules 12(b) (1) and (6) of the Federal Rules of Civil Procedure for an order dismissing the complaint herein for lack of jurisdiction over the subject matter and failure to state a claim upon which relief can be granted. This motion is based upon the complaint herein, the attached Memorandum and the affidavit of Anthony D. Mitten sworn to November 17, 1978.

(Signatures omitted in printing.)

Filed - NOV. 17, 1978
W. J. Furstenau, Clerk
U. S. District Court
For The District of Arizona

(Caption omitted in printing.)

MEMORANDUM IN SUPPORT OF DEFENDANT MARICOPA FOUNDATION FOR MEDICAL CARE'S MOTION TO DISMISS THE COMPLAINT

THE ACTIVITIES OF MARICOPA FOUNDATION WHICH PLAINTIFF ALLEGES TO BE UNLAWFUL ARE EXEMPTED FROM THE FEDERAL ANTITRUST LAWS BY THE McCARRAN-FERGUSON ACT BECAUSE THEY CONSTITUTE THE "BUSINESS OF INSURANCE" AND ARE REGULATED BY ARIZONA.

Although the allegations of the complaint are vague and ambiguous (see Defendant's Motion for a More Definite Statement), it is clear from plaintiff's Memorandum in Support of Application for Order to Show Cause and Motion for Preliminary Injunction, dated October 25, 1978, that the activity of Maricopa Foundation for Medical Care ("Maricopa Foundation") which plaintiff contends to be unlawful consists of its endorsement, promotion and administration of heath insurance plans.

> "*The framework for the defendants' unlawful combination lies in agreements between the foundations and certain health insurers.* Under those agreements the foundations endorse, promote and administer certain health insurance plans (hereinafter 'foundation plans') which are underwritten by the insurers. In return, the insurers must provide coverage for the wide range of doctors' services set out in the foundations' minimum standards and agree to pay for covered services, goods and products sold by doctors to foundation policyholders at the prices fixed by the foundation fee schedule. As a term of membership in the foundation, doctors agree to accept the prices fixed

by the foundation fee schedule as full payment for assigned claims of foundation policyholders. The doctors submit such assigned claims directly to the foundations. The review and payment of those claims is performed by foundation members; in the case of specialists, the review is performed by members of the same specialty."

Pages 4-5. (Emphasis added)

As plaintiff states in its complaint, "Defendants Maricopa Foundation and Pima Foundation endorse certain health insurance plans (hereinafter referred to as 'Foundation Plans') which are underwritten by private insurers in the State of Arizona and elsewhere and meet certain 'minimum standards' formulated by defendants. Those minimum standards include, among other things, coverage of a wide range of services, goods and equipment sold by doctors. Defendants and their co-conspirators set the prices which the insurers must pay under Foundation Plans for covered services, goods and products sold by doctors to Foundation policyholders."

(Paragraph 13). The complaint further alleges that the Sherman Act Section 1 violation consists of a conspiracy, pursuant to which Maricopa Foundation

"(h) entered into agreements with health insurers that the insurers pay for covered services, goods and products sold to Foundation policyholders by doctors at prices set by defendants and their co-conspirators;

(i) required as a term of membership in the Maricopa Foundation or Pima Foundation that Foundation members accept payment on assigned claims for services, goods and products sold to Foundation policyholders in accordance with Foundation fee schedules;

(j) gave advance notice of planned increases in Foundation fee schedules to health insurers so that the resulting increases in prices charged by doctors were passed on to Foundation subscribers through increased health insurance premiums;

(k) controlled the review and administration of claims for services, goods and products sold by doctors to Foundation policyholders."

(Complaint, paragraph 16).

The complaint further alleges "The prices doctors charge for their services, goods and products have a direct and substantial effect upon payments made to and premiums charged by insurers" (paragraph 12) and that an effect of the alleged conspiracy is that "The cost of health insurance has been increased." (Complaint, paragraph 17) Maricopa Foundation does not believe that the allegations of the complaint or charges in the preliminary injunction papers accurately represent the functions of the Maricopa Foundation, particularly in their unfounded accusations that Maricopa Foundation has increased the price of medical services. The facts will prove, to the contrary, that Maricopa Foundation has been a substantial factor in reducing the cost of medical services and retarding price increases. Nevertheless, it is respectfully submitted that the allegations of the complaint, viewed in light of the admissions by plaintiff in its Motion for Preliminary Injunction, demonstrate that Maricopa Foundation is exempted from the federal antitrust laws by the McCarran-Ferguson Act.

The McCarran-Ferguson Act, 15 U.S.C. §§ 1011-1015,[1] exempts the "business of insurance" from application of the Sherman Act to the extent that such business is regulated by state law. In construing the Act, federal courts consistently have held that the "business of insurance" is not limited to activities of insurance companies; the focus of the exemption is on the nature of the conduct under attack, not on the nature of the entity engaging in the challenged conduct. If challenged activities touch upon the "core of the 'business of insurance,' " defined by the Supreme Court to include "the fixing of rates . . . the selling and advertising of policies . . . the type of policy which [can] be issued, its reliability, interpretation, and enforcement . . . ,"[2] and if they are subject to regulation by state law, federal laws which might otherwise supersede the state regulatory scheme do not apply. *E.g., Lowe v. Aarco-American, Inc.*, 536 F.2d 1160, 1162 (7th Cir. 1976) (applying the McCarran-Ferguson Act to exempt an insurance broker and a premium finance company from the Turth in Lending Act; "the fact that neither appellee is an insurance company does not take the disputed transaction outside the scope of the 'business of insurance' "); *General Glass Co., Inc. v. Globe Glass and Trim Co.*, [1978-1]

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[1] 15 U.S.C. § 1012 provides:

(a) The business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business.

(b) No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance: *Provided*, That after June 30, 1948, the Act of July 2, 1890, as amended, known as the Sherman Act, and the Act of October 15, 1914, as amended, known as the Clayton Act, and the Act of September 26, 1914, known as the Federal Trade Commission Act, as amended, shall be applicable to the business of insurance to the extent that such business is not regulated by State law.

[2] *SEC v. National Securities, Inc.*, 393 U.S. 453, 459-60 (1969) (reversing a decision which applied the McCarran-Ferguson Act to exempt from the federal securities laws a contemplated merger of insurance companies because the state regulatory scheme did not constitute regulation of the business of insurance).

Trade Reg. Rep. (CCH) ¶ 62,231 (N.D. Ill. Sept. 13, 1978) (granting summary judgment for defendant auto glass replacement firms because their agreements with respect to pricing and billing procedures with automobile insurers constituted the business of insurance; "the claims-settlement procedures have a direct connection with an insurance company's ratemaking structure. Almost axiomatic is the fact that the cost of repairs, including labor charges . . . paid in settlement of damage claims are an important factor in the ratemaking structure." *Id.* at 75,489).

A. The Foundation is Engaged in the "Business of Insurance".

With the exception of one decision, the appeal from which is now sub judice in the Supreme Court, federal courts which have considered applicability of the McCarran-Ferguson Act to agreements among suppliers of health care services and insurers have held the agreements to constitute the "business of insurance" because of their direct impact upon the insurance ratemaking process.[3]

In a case strikingly similar to this, *Anderson v. Medical Service*, [1976-1] *Trade Reg. Rep.* (CCH) ¶ 60,884 (E.D. Va. Feb. 10, 1976), *aff'd mem.*, 551 F.2d 304 (4th Cir. 1977), the court dismissed the Sherman Act complaint filed by a physician against a non-profit corporation engaged in selling prepaid medical services because Medical Service's activities were part of "the business of insurance". Like the Maricopa Foundation's insurance plans, Medical Service patients who were treated by participating physicians pursuant to its UCR plan were assured that their treatment would be fully paid by their insurance because those physicians had agreed to accept

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[3] *Royal Drug Co. v. Group Life & Health Ins. Co.*, 556 F.2d 1375 (5th Cir. 1977), *cert. granted*, 98 Sup. Ct. 1448 (1978) stands virtually alone in its holding that a prepaid pharmaceutical insurance plan, which involved an agreement by pharmacies to provide drugs at pre-determined rates, did not constitute the business of insurance. The matter was argued to the Supreme Court on October 11, 1978, but it has not yet rendered its opinion. [1978] *Trade Reg. Rep.* (CCH) ¶ 60,021.

the insurer's payment as payment in full, even though the physician's usual and customary fees may have been higher. (Mitten aff., para. 4) The level of reimbursement under the UCR plan was ordinarily the physician's usual and customary fee charged for the services rendered up to a maximum reimbursement level set by Medical Service. The Maricopa Foundation and Medical Service UCR plans are parallel in other significant respects: (1) in both patients are in no way restrained from seeking treatment from non-participating physicians—they receive exactly the same benefits regardless of the service provider; in both cases they are, however, liable for physician fees exceeding the maximum level of benefits if a non-participating physician charges more than the plan's maximum reimbursement level (Mitten aff., para. 4); (2) a significant percentage of area physicians are enrolled as participating members of the corporations;[4] (3) the contracts between participating physicians and each corporation are "nothing more than an agreement on the part of the doctor to accept as full payment for medical services rendered Medical Service's policyholders the charge computed by the UCR formula." [1976-1] *Trade Reg. Rep.* (CCH) ¶ 60,884 at 68,857; Mitten aff., para. 3; and (5) physicians charge their patients, including Foundation or Medical Service plan patients, whatever they deem proper.[5] *Id.* at 68,858; Mitten aff., para. 3.

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[4] The complaint alleges over 70% of the licensed physicians in Maricopa County are enrolled in the Maricopa Foundation as participating members (para. 8(b)) while 93% of the practicing physicians in the Washington metropolitan area were enrolled in Medical Service. [1976-1] *Trade Reg. Rep.* (CCH) ¶ 60,884 at 68,856.

[5] Moreover, Foundation physicians expressly agree as a condition of membership that their participation in the plan will not affect the method or amount they *charge* their patients for services rendered. Their only agreement, in connection with compensation, is to accept as payment in full the level of reimbursement provided under the Foundation plan. [Mitten aff., para. 3, 4; Ex. A]

Another prepaid health care services insurance program, strikingly parallel to the Foundation plan, was found exempt from federal antitrust attack in the leading decision on applicability of the McCarran-Ferguson Act to health care within the Ninth Circuit. *Manasen v. California Dental Services*, 424 F. Supp. 657 (N.D. Cal. 1976).[6] Accepting the well-established notions that "the 'business of insurance' may embrace arrangements between insurance companies and nonpolicyholders, including service providers" and that "a wide variety of activities which have a substantial effect on ratemaking, including the settlement of claims and the limitation of costs. . . ," the court held that California Dental Service's (CDS) payment arrangements to the providers of health services constituted the "business of insurance" within the meaning of the McCarran-Ferguson Act and granted CDS' motion for summary judgment. 424 F. Supp. at 666. In reaching its decision, the court stated:

> "Plaintiffs here contend that it is an antitrust violation for CDS to pay service providers prevailing rates for the services rendered to insured patients. It is undisputed that the level of dentists' fees are a major factor in determining policy premiums. CDS' payment

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[6] Like CDS, the Foundation offers prepaid health care services under which subscribers pay periodic premiums in exchange for the agreement of the Foundation membership to provide designated services at predetermined rates. While CDS assumed direct actuarial risk, independent insurance carriers or self-insurers assume that risk under the Foundation plan. Mitten aff., para. 2. The distinction is immaterial, however, because in CDS as here, "the plaintiffs' primary challenge is directed at the method and manner by which CDS compensates those dentists who provide the services for which CDS accepts claims and underwrites risks. 424 F. Supp. at 665. The manner of compensation at issue in *Manasen*, like the manner of compensation at issue here, involved the agreement of participating dentists to accept as full reimbursement payment provided by CDS pursuant to a pre-established schedule. CDS schedule limited compensation to the ninetieth percentile of the usual, customary and reasonable fees charged by area dentists for any particular procedure, unless a peer review group determined that a higher fee was reasonable under the circumstances. 424 F. Supp. at 661.

> arrangements to service providers are critical elements in CDS' contractual agreements with its subscribers. These arrangements are intimately related to the interpretation and implementation of CDS' policies and to its reliability as an insurer. Accordingly, the Court finds that the activities challenged in the instant complaint constitute part of the "business of insurance" within the meaning of the McCarran Act." (footnotes omitted)

424 F. Supp. at 666-67.

Similarly, the level of the Foundation's reimbursement to participating physicians is a major factor in determining the policy premiums of the group insurance plans it endorses. In establishing premium rates, underwriters use the Foundation's reimbursement levels as the basis for their actuarial calculations. Plaintiff so alleges in the complaint. Para. 12, 13, 16(j), 17(i). According to *Manasen*, the close relationship of the Foundation's compensation schedule, together with its claims processing activities, without more, is sufficient to bring its challenged activities within the business of insurance.

A series of cases in a related health services area—hospital care—further compel the conclusion that the very activities which the State of Arizona alleges to be violative of the federal antitrust laws clearly constitute the "business of insurance." *E.g., Travelers Ins. Co. v. Blue Cross*, 481 F.2d 80 (3d Cir.), *cert. denied*, 414 U.S. 1093 (1973) (antitrust claim alleging that Blue Cross' standard contract entered into with more than one hundred hospitals in Western Pennsylvania, prescribing the terms and amounts of compensation to be paid the providers for hospital care rendered to Blue Cross subscribers, dismissed because the agreements were within the "business of insurance."); *Frankford Hospital v. Blue Cross*, 417 F. Supp. 1104 (E.D. Pa. 1976), *aff'd per curiam*, 554 F.2d 1253 (3d Cir.), *cert. denied*, 434 U.S. 860 (1977); *Doctors, Inc. v. Blue Cross*, 431 F. Supp. 5 (E.D. Pa. 1975), *aff'd per curiam*, 557 F.2d 1001 (3d Cir. 1976); *Nankin Hospital v. Michigan Hospital Ser-*

vice, 361 F. Supp. 1199 (E.D. Mich. 1973); *Winters v. Kansas Hospital Service Ass'n, Inc.*, [1975] *Trade Reg. Rep.* (CCH) ¶ 60,140 (D. Kan. Dec. 26, 1974).

B. The State of Arizona Regulates Maricopa Foundation's Activities.

The conduct which the State of Arizona challenges, including entering into agreements with insurers and engaging in claims processing and review,[7] are clearly regulated by the States' own comprehensive statutory insurance scheme. No only are the challenged insurance agreements (which incorporate the provisions of the Foundation's minimum standards) subject to regulation by the Arizona Department of Insurance[8] but the activities of the Foundation itself are directly regulated by that administrative agency. [Mitten aff. paras. 5-6] As an insurance administrator,[9] the Maricopa Foundation may not act "without a written agreement between [the Foundation] and an insurer,[10] and the agreement, which is subject to audit and review by the director of insurance,[11] must contain provisions "with respect to the underwriting or other

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[7] The State alleges at paragraphs 16(h) and (k) of its complaint that the Foundation "entered into agreements with health insurers that the insurers pay for covered services, goods and products sold to Foundation policyholders by doctors. . . ." and "controlled the review and administration of claims for services, goods and products sold by doctors to Foundation policyholders."

[8] *See generally* A.R.S. § 20-1341 to 20-1376 and §§ 20-1401 to 20-1406, pertaining to disability insurance, defined by A.R.S. § 20-253 to include "expense resulting from sickness, and every insurance appertaining thereto" and A.R.S. §§ 20-441, -442 and -446 prohibiting unfair trade practices in the business of insurance.

[9] The Foundation was notified by the Director of the Department of Insurance in January 1978, that it was an "insurance administrator" within the meaning of A.R.S. § 20-485 and therefore subject to regulation by that department. The Foundation has registered pursuant to A.R.S. § 20-485.12. [Mitten aff., paras. 5-6]

[10] A.R.S. § 20-485.01(A).

[11] A.R.S. § 20-485.03.

standards pertaining to the business underwritten by such insurer."[12]

The Insurance Laws of Arizona contain in Title 20, Chapter 2, Article 6, A.R.S. a number of sections giving the Department of Insurance power to prevent unfair practices. A.R.S. § 20-441 provides:

> "Among the purposes of this article is the regulation of trade practices in the business of insurance in accordance with the intent of Congress as expressed in the Act of Congress of March 9, 1945, 59 Stat. 33 [15 U.S.C.A. § 1011 et seq.], by defining, or providing for the determination of, all such practices in this state which constitute unfair methods of competition or unfair or deceptive acts or practices and by prohibiting the trade practices so defined or determined."

Even absent the specific provisions of the Insurance Laws regulating the Maricopa Foundation, it would still be exempted from the Sherman Act by the McCarran-Ferguson Act. It is not necessary that the state regulatory scheme "seek to implement the policies expressed in the federal antitrust laws," nor is it necessary that the scheme be effective. "Indeed, the mere existence of regulatory statutes capable of being enforced is sufficient to invoke the protection of the McCarran Act." *Manasen v. California Dental Services*, 424 F. Supp. at 667. *Accord, Commander Leasing Co. v. Transamerica Title Ins. Co.*, 477 F.2d 77, 84 (10th Cir. 1973); *Ohio AFL-CIO v. Insurance Rating Board*, 451 F.2d 1178, 1184 (6th Cir. 1971), *cert. denied*, 409 U.S. 917 (1972); *California League of Independent Ins. Producers v. Aetna Casualty & Surety Co.*, 175 F. Supp. 857, 860 (N.D. Cal. 1959) ("... a State regulates the business of insurance ... when a State statute generally proscribes ... or permits or authorizes certain conduct on the part of the insurance companies.")

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[12] A.R.S. § 20-485.05.

Because the activities of the Foundation, as set forth in the State of Arizona's complaint, constitute the "business of insurance" subject to regulation by the State, the McCarran-Ferguson Act exempts the Foundation from application of federal antitrust laws and Count One of the complaint, therefore, should be dismissed.

IF PLAINTIFF'S FEDERAL ANTITRUST CLAIM IS DISMISSED, THE STATE ANTITRUST CLAIMS SHOULD BE DISMISSED AS WELL.

Plaintiff's complaint alleges two causes of action. Count One alleges violations of Section 1 of the Sherman Act, 15 U.S.C. § 1, with jurisdiction conferred by 28 U.S.C. § 1331 and 1337 and 15 U.S.C. § 26. Count Two alleges violations of the Uniform State Antitrust Act. A.R.S. §§ 44-1401, *et seq.* The sole basis alleged by plaintiff to give this Court jurisdiction over the state law claim of Count Two is pendent jurisdiction. (Complaint, paragraph 2). If the federal claims of Count One are dismissed, the basis for pendent jurisdiction would no longer exist and the state law claim should also be dismissed for lack of subject matter jurisdiction pursuant to Fed. R. Civ. P. 12(b)(1).

The landmark case on pendent jurisdiction is *United Mine Workers of America v. Gibbs*, 383 U.S. 715, 726 (1966). In that decision, Justice Brennan explained the principles of pendent jurisdiction as follows:

> "It has consistently been recognized that pendent jurisdiction is a doctrine of discretion, not of plaintiff's right. Its justification lies in considerations of judicial economy, convenience and fairness to litigants; if these are not present a federal court should hesitate to exercise jurisdiction over state claims ... *Certainly, if the federal claims are dismissed before trial, even though not insubstantial in a jurisdictional sense, the state claims should be dismissed as well.*" (Emphasis added.)'

The situation described by Justice Brennan exists in this case. If the federal claims are dismissed with respect to Maricopa Foundation, it would be an abuse of discretion not to also dismiss the state claims.

Numerous Ninth Circuit decisions have applied the principle set forth above to dismiss state law pendent claims not decided on their merits prior to dismissal of all claims over which the federal court had statutory jurisdiction. *Hodge v. Mountain States Tel. & Tel. Co.*, 555 F.2d 254, 261 (9th Cir. 1977), (Affirming the district court's summary judgment for defendant on the federal claims; "remand[ing] the state law claims to the district court with instructions to dismiss for want of federal jurisdiction."); *Toensing v. Brown*, 528 F.2d 69, 72 (9th Cir. 1977), (Affirming the district court's summary judgment for defendant on the federal claim and the dismissal of the pendent state claim. "Upon dismissal of the federal claim before trial, a proper exercise of discretion required dismissal of the pendent state claim."); *National Ass'n of B.E.T. v. International All. of T.S.E.*, 488 F.2d 124 (9th Cir. 1973), (Affirming the district court's dismissal of the federal antitrust claim on the pleadings and the dismissal of the pendent state claim.); *Walling v. Beverly Enterprises*, 476 F.2d 393, 398 (9th Cir. 1973), (Reversing and remanding dismissal of a federal securities claim for lack of subject matter jurisdiction with instruction that "... if the federal claim is dismissed prior to trial, the state claims should be dismissed as well so that federal jurisdiction will not be abused."); *Wham-O-Mfg. Co. v. Paradise Mfg. Co.*, 327 F.2d 748, 753 (9th Cir. 1964) (Affirming dismissal of a federal claim for patent infringement and a state claim for unfair competition. The district court acting sua sponte had dismissed the unfair competition claim. Once the federal

claim was dismissed, on summary judgment, the district court, "in the exercise of a sound discretion, had no choice but to dismiss the complaint with respect to [the state] claim.")

On the basis of the foregoing cases, if the federal claims of Count One are dismissed or sticken, defendant respectfully requests this Court to dismiss without prejudice the state law claim of Count Two for lack of subject matter jurisdiction.

Conclusion

For the foregoing reasons, plaintiff's complaint should be dismissed in its entirety.

November 17, 1978.

(Signatures omitted in printing.)

(Caption omitted in printing.)

AFFIDAVIT OF
ANTHONY D. MITTEN

STATE OF ARIZONA }
} ss.
County of Maricopa }

ANTHONY D. MITTEN, being duly sworn, under oath deposes and says:

1. I am the Executive Director of defendant Maricopa Foundation for Medical Care ("Maricopa Foundation") herein. I make this affidavit in support of Maricopa Foundation's Motion to Dismiss the Complaint.

2. The Maricopa Foundation was established to provide residents of Maricopa County with a competitive alternative to utilization of closed panel prepaid health insurance plans. Its activities include establishment of minimum standards for insurance plans for which Maricopa Foundation will perform peer review and administrative functions. Maricopa Foundation reviews the medical necessity and appropriateness of treatment and, for certain insured groups, also reviews utilization of hospital services. Following the medical review by the Maricopa Foundation, it makes payment on claims for certain insured groups. In each instance, Maricopa Foundation acts as an agent of an insurer who underwrites the health insurance plan. When Maricopa Foundation pays claims, it draws funds from bank accounts of the insurer with respect to which it has the power to issue drafts as the insurer's agent.

3. Membership in Maricopa Foundation is open to all physicians licensed to practice in Arizona without regard to whether they are members of any medical society. Each participating member in Maricopa Foundation executes an application for membership, a true copy of which is attached hereto as Exhibit "A". That application for membership specifically states "I understand and agree that participating membership in the Foundation shall not

affect the method of computation or amount of fees billed by me with respect to any medical care for any patient." Participating members further agree "to be bound during the period of the membership applied for with respect to maximum fees charged patients covered by Foundation sponsored plans by any fee determination by the Foundation consistent with the schedule adopted by the membership and agree also to be bound with respect to patients covered by Foundation sponsored plans during the period of membership applied for by any agreements, contracts, or statements of policy entered into or adopted by the Foundation concerning the rendering of medical care and the cost thereof."

4. The only determinations with respect to fees charged for medical services which are made by Maricopa Foundation are with respect to maximum fees paid with respect to patients covered by Foundation endorsed plans to participating members in Maricopa Foundation. They agree to accept the Foundation's determination of maximum fees as payment in full for services performed by them on patients covered by Foundation endorsed plans when they bill the patient more than that amount. If the patient is billed less than that amount, the physician is paid the amount billed if the services are determined by Maricopa Foundation to have been medically appropriate. Maricopa Foundation does not and never has taken any position with respect to the amount of fees a participating member or other physician should bill with respect to any medical care for any patient. Patients covered by Foundation endorsed plans receive the same insurance benefits with respect to treatment by physicians who are not participating members as they would receive if treated by a participating member.

5. In 1977, Arizona enacted Article 9 to Title 20, Chapter 2 of Arizona Revised Statutes, the Title pertaining to regulation of the business of insurance in Arizona. That Article, which became effective August 27, 1977, provides for regulation by the Department of Insurance of the State of

Arizona of "insurance administrators" as defined in A.R.S. § 20-485. After enactment of Chapter 9, I consulted with Jack Trimble, Director of the Arizona Department of Insurance, as to whether Maricopa Foundation was an insurance administrator as defined by A.R.S. § 20-485. In January 1978, I received a response to my inquiry to Mr. Trimble from Clarence E. Newman, Jr. auditor in the Department of Insurance of the State of Arizona, informing me that "It has been determined that the functions that your organization performs are within the definition of an insurance administrator as defined under § 20-485 of the Insurance Administrators' Law" and enclosing forms to be completed by Maricopa Foundation in order to register under that law.

6. Maricopa Foundation has submitted registration forms to the Department of Insurance of the State of Arizona in the form required by it and those forms have been accepted by the State of Arizona Department of Insurance. As a result, Maricopa Foundation is duly regulated by the Department of Insurance of the State of Arizona under the insurance laws of the State of Arizona.

(Signature and notarization
omitted in printing.)

Filed - NOV 20, 1978
W. J. Furstenau, Clerk
U. S. District Court
For The District of Arizona

ıtion omitted in printing.)

Deposition of MARY GERDENICS

November 14, 1978

Tucson, Arizona

[4]

* * * Would you please state your name and home ess?

Mary Gerdenics, 2001 West Brichta; Tucson, Arizona, i-c-h-t-a.

* * * *

By whom are you employed?

The Greater Southern Arizona PSRO.

What is your position with the Greater Southern Ari- PSRO?

I'm the administrative assistant.

What are your responsibilities as Administrative As- nt of the Greater Southern

[5]

ɔna PSRO?

Okay. I'm the bookkeeper; I take care of all the ac- ts; I'm responsible for the over-all running of the e, itself, as far as —

And how long have you held that position.

Since October, 1977.

What position did you hold prior to becoming the inistrative assistant for the Greater Southern Arizona O?

A. I was the executive secretary for the Pima Foundation for Medical Care.

Q. What were you responsibilities as Executive Secretary for the Pima Foundation for Medical Care?

A. I was the bookkeeper and secretary to the board of directors.

* * * *

[20]

Q. Would you briefly describe the method in which the Pima Foundation performs claims' payment on Foundation plans and when I say "Foundation plans," let us understand that I'm referring to — A. Uh-huh.

Q. — plans that are endorsed by the Pima Foundation.

A. Well, I don't pay claims myself, so I don't know how they do them, but I know they follow the guidelines established by the insurance companies involved, so — But, how they pay claims, I don't know. I don't know the actual process.

Q. As the bookkeeper and secretary to the board for the Pima Foundation, was it your understanding that the Foundation paid claims specifically in accordance with the guidelines of the insurance companies that underwrote those policies?

A. Yes, they have to follow their guidelines, establised guidelines.

Q. The Pima Foundation does not assume any actuarial risk or underwrite any actuarial risk under Foundation plans; is that correct? A. That's correct.

* * * *

[25]

* * * *

Q. . . . [H]ow would you use the numbers to determine the allowable price?

A. Well, say an office visit would have a 1.0 units assigned; you would multiply your 1.0 units times your medicine schedule to come up with what you would pay for that particular procedure?

Q. So, in other words, you would multiply the dollar amount in the appropriate category times the relative value accorded a specific procedure? A. Yes, un-huh.

Q. In order to determine a price, then, with the Foundation fee schedule, it is necessary to use a relative value schedule? A. Yes, uh-huh.

Q. And conversely, the relative value schedule is part of the fee schedule of the Pima Foundation? A. Yes, uh-huh.

* * * *

[28]

* * * *

Q. In Paragraph Three of Exhibit 6, the letter states: The Foundation plan to be offered meets the minimum standards of the Pima Foundation for Medical Care for plans to be presented as under our auspices. A. Um-hum.

Q. Does a plan have to meet all minimum standards of the Pima Foundation in order to be presented under the auspices of the Pima Foundation? A. Yes.

Q. Paragraph Four, Number One, states that Pima Foundation for Medical Care members are to abide by a fee schedule related to 1964 CRV and there follows a list of medical categories with a dollar amount next to each cagetory. Does this mean that the Pima Foundation members have agreed to abide by the use of the 1964 California Relative Value Schedule with those conversion factors? A. Yes.

Q. Are the numbers used to multiply the relative values in the California Relative Value Schedule commonly referred to as conversion factors? A. Yes, they are.

Q. So if I use the term "conversion factors" to identify those dollar amounts, we'll understand each other?

A. It's easier to understand, yes.

Q. Correct? A. Yes, uh-huh.

Q. .In Subparagraph Four on Page One of Exhibit 6, the letter states that: The Foundation agrees to request the Maricopa Foundation to honor this program according to our previous agreements with the Maricopa Foundation to give the program broader state coverage.

[29]

What type of agreements does the Pima Foundation have with the Maricopa Foundation which would give such a program broader state coverage?

A. The Pima and Maricopa physicians agree to the same contract — What I mean is if a member — If someone who has a Pima Foundation contract would go to Phoenix to a physician who is a member of the Maricopa Foundation, then they would — It was if they were going to a Pima Foundation physician; they would not be charged for the difference. It is almost as if they, belonging to one organization, you belong to the other.

Q. So, it — A. I'm not saying this very well, but that's the only way I can —

Q. Would it be correct to say, then, that the members of the Maricopa Foundation honor the fee schedule agreed to by the members of the Pima Foundation?

A. Yes, on a given contract.

Q. And conversely, do the members of the Pima Foundation agree to use or to recognize on certain contracts the fee schedule agreed to by the members of the Maricopa Foundation? A. Yes, uh-huh.

* * * *

[30]

* * * *

Q. .... At what time did the Foundation begin to pay claims?

A. I think it was in January, 1976.

* * * *

[47]

Q. If you would be kind enough to clarify for me the manner in which this [California Relative Value Schedule and the ASA Guide] is used.

At Page Nine, taking a simple value, Procedure 9004 under medicine is labeled as: Follow-up Office Visit, Routine, and has a unit value of one; is that correct?

A. Yes, uh-huh.

Q. If the conversion factor for medicine is ten, then the fee charged for a routine follow-up office visit would be ten? A. Yes, uh-huh.

Q. And if the conversion factor for medicine is 12, then the fee charged for a routine follow-up office visit is 12? A. Yes.

Q. If the value of Procedure 9004 labeled: Follow-up Office Visit, Routine, were increased to 1.5, then the price of that office visit would be increased by 50 percent; is that correct? A. Yes, uh-huh.

Q. And if the doctor were a surgeon or anesthetist, would he still use the conversion

[48]

factor for medicine to compute the price for services listed in the medicine section of the California Relative Value Schedule? A. I don't understand exactly —

Q. Does the choice of conversion factor depend on the category of the procedure within the relative value schedule, or the specialty of the particular doctor? A. The procedure.

Q. I see. So, the categorization of the conversion factors into those five or six categories refers to sections of the relative value schedule — A. Yes.

Q. — rather than to a person's actual — A. Yes.

Q. — method of practice or category of practice. I see.

Just to clarify again, then, if the unit value of one procedure is increased, the price is increased only for that one procedure; is that right? A. Yes, if you only increase one.

Q. Okay, but if the conversion factor is increased, it raises the prices of all the procedures within the category of that conversion

[49]

factor? A. Yes.

* * * *

Filed - NOV 20, 1978
W. J. Furstenau, Clerk
U. S. District Court
For The District of Arizona

(Caption omitted in printing.)

PLAINTIFF'S MOTION FOR PARITAL SUMMARY JUDGMENT ON THE ISSUE OF LIABILITY AND NOTICE OF HEARING

Plaintiff STATE OF ARIZONA moves pursuant to Rule 56(a), Federal Rules of Civil Procedure, for entry of an order awarding partial summary judgment in its favor and against defendants that defendants' actions are in violation of section 1 of the Sherman Act, 15 U.S.C. § 1, and the Uniform State Antitrust Act, Ariz. Rev. Stat. Ann. § 44-1402. This motion is based upon the accompanying statement of facts and memorandum of law and the entire record herein.

PLEASE TAKE NOTICE that this motion will be heard on December 11, 1978 at 10:00 a.m.

DATED this 20th day of November, 1978.

(Signatures omitted in printing.)

Filed - NOV 20, 1978
W. J. Furstenau, Clerk
U. S. District Court
For The District of Arizona

(Caption omitted in printing.)

MEMORANDUM IN SUPPORT OF PLAINTIFF'S MOTION FOR PARTIAL SUMMARY JUDGMENT ON THE ISSUE OF LIABILITY

I. INTRODUCTION

Plaintiff, STATE OF ARIZONA, has brought this action on its own behalf and as *parens patriae* on behalf of the citizens of Arizona for injunctive and declaratory relief from defendants' continuing violations of the antitrust laws. The undisputed facts in this matter establish that defendants' ongoing activities constitute *per se* violations of section 1 of the Sherman Act, 15 U.S.C. § 1, and the Uniform State Antitrust Act, Ariz. Rev. State. Ann. § 44-1402. Plaintiff therefore requests that the Court enter partial summary judgment in its favor and against defendants on the issue of liability.

There is no dispute that the defendant foundations are combinations of doctors which formulate, adopt and circulate comprehensive schedules of fees for services, goods and products sold by doctors. More than 1,000 doctors in Maricopa County and more than 400 doctors in Pima County have signed agreements to abide by the foundation fee schedules. It is also undisputed that during the four year period prior to the filing of the complaint in this matter, increases in the foundation fee schedules were periodically adopted by mail ballot of the foundation membership, and that such price increases typically followed price surveys and consultations with defendants' members and various doctors' associations regarding desirable relative value

schedules and conversion factors. Defendants do not and cannot dispute that they and their members have used and continue to use agreed-upon fee schedules to set prices for services, goods and products sold by doctors in Arizona.

From their inception, the foundations have functioned as arms of the defendant medical societies. It is not disputed that the societies created the foundations for the purpose of promoting the interests of "fee-for-service medicine,"[13] and that the foundations' pricing agreements have been formulated and adopted with the knowledge and approval of the societies. Indeed, the foundations' By-laws[14] have granted member doctors only the limited right to vote on uniform, average or median fee schedules, while vesting the general voting power exclusively in the members of the societies' elected boards of directors.

Defendants' conspiracy has been effectuated through agreements between the foundations and certain health insurers which underwrite foundation plans. Those agreements require the insurers to pay doctors for covered services to foundation policyholders at the prices fixed by foundation fee schedules and to provide coverage for the wide range of doctor's services defined in defendants' minimum standards for foundation plans. Under those agreements, defendants' members may submit claims which foundation policyholders have assigned to them in advance directly to the foundations for payment. The review and

[13] "Fee-for-service medicine" refers to the sale of doctor's services in return for fees based upon the services rendered, as opposed to work performed for a salary or for capitation payments.

[14] Since this action was filed, the By-laws of the Pima Foundation for Medical Care have been amended to sever the relationship between that foundation and the Pima County Medical Society. Gerdenics Deposition, pp. 70-72. A stipulated Judgment against the Pima County Medical Society was filed on November 17, 1978. The Maricopa County Medical Society remains a defendant herein.

payment of claims on foundation plans is performed by foundation members. Thus, the foundations have eliminated third party review of doctors' bills under foundation plans.

Defendants' fee schedules come in two parts: the relative value schedule and the "foundation fee schedule" of unit conversion factors. A relative value schedule is a compilation of doctor's services which assigns a relative unit value to each service listed. A unit conversion factor is a number or dollar figure used to multiply the unit value for any doctor's service into a dollar figure payable for that service. The foundation fee schedule provides unit conversion factors for six categories of relative values. By multiplying the unit value for each procedure by the foundation conversion factor in that category, doctors can determine the price approved by the foundation membership for each procedure found in the relative value schedule.

By agreement, defendants use certain relative value schedules which were originally developed by the California Medical Association, American Society of Anesthesiologists and American College of Radiology. Defendants have maintained and updated those relative value schedules by agreeing upon relative values for new and additional procedures, and by providing instructions for uniform use of those schedules by their members. At the request of various doctors' associations, defendants have adjusted the prices for some procedures by increasing the unit values for those procedures. In addition, the Maricopa Foundation has devoted considerable effort to the preparation of a special relative value schedule for Arizona doctors.

In a deposition taken on November 14, 1978, the designee of the Pima Foundation for Medical Care, Ms. Mary Gerdenics, explained the way in which agreed-upon relative value schedules and conversion factors are used by defendants and their members. Deposition of Pima Foundation for Medical Care by its designee Mary Gerdenics, taken November 14, 1978, filed November 20, 1978 (hereinafter

"Gerdenics Deposition") pp. 24-26, 41-49. Referring to the Pima Foundation's edition of the California Relative Value Schedule (Gerdenics Deposition Exhibit 18), the foundation's representative related the method by which uniform prices are computed with foundation fee schedules:

> A. Well, say an office visit would have a 1.0 units assigned; you would multiply your 1.0 units times your medicine schedule to come up with what you would pay for that particular procedure.
>
> Q. So, in other words, you would multiply the dollar amount in the appropriate category times the relative value accorded a specific procedure?
>
> A. Yes, uh-huh.
>
> Q. In order to determine a price, then, with the Foundation fee schedule, it is necessary to use a relative value schedule?
>
> A. Yes, uh-huh.
>
> Q. And conversely, the relative value schedule is part of the fee schedule of the Pima Foundation?
>
> A. Yes, uh-huh.

Gerdenics Deposition, pp. 25-26.

Later in the same deposition, the witness confirmed that increasing the unit value assigned to a procedure in the relative value schedule would increase the price charged for that procedure, whereas an increase in the foundation's conversion factor would raise prices across the board in the increased category.

> Q. If you would be kind enough to clarify for me the manner in which this is used.
>
> At Page Nine, taking a simple value, Procedure 9004 under medicine is labeled as: Follow-up Office Visit, Routine, and has a unit value of one; is that correct?

A. Yes, uh-huh.

Q. If the conversion factor for medicine is ten, then the fee charged for a routine follow-up visit would be ten?

A. Yes, uh-huh.

Q. And if the conversion factor for medicine is 12, then the fee charged for a routine follow-up office visit is 12?

A. Yes.

Q. If the value of Procedure 9004 labeled: Follow-up Office Visit, Routine, were increased to 1.5, then the price of that office visit would be increased by 50 percent; is that correct?

A. Yes, uh-huh.

Just to clarify again, then, if the unit value of one procedure is increased, the price is increased only for that one procedure; is that right?

A. Yes, if you only increase one.

Q. Okay, but if the conversion factor is increased, it raises the prices of all the procedures within the category of that conversion factor?

A. Yes.

Thus, the testimony of the foundation's own representative establishes that defendants' use of agreed-upon relative value schedules and conversion factors results in uniform pricing and uniform step increases in doctors' prices. This type of pricing agreement is, as a matter of law, a *per se* violation of section 1 of the Sherman Act and the Uniform State Antitrust Act.

II. ARGUMENT

A. Defendants' Use of Agreed-Upon Relative Value Schedules and Conversion Factors Constitutes a Per Se Violation of Section 1 of the Sherman Act.

Under section 1 of the Sherman Act, 15 U.S.C. § 1, any combination which tampers with price structures is unlawful on its face. *United States v. Socony-Vacuum Oil Co.*, 310 U.S. 150, 221, 60 S.Ct. 811, 843 (1940). Because any combination or agreement which restrains price competition undermines the strong public policy favoring a competitive marketplace, the Supreme Court has consistently ruled that *any* agreement to fix, raise, maintain or stabilize prices is *per se* unlawful, even if the price fixed is purported to be reasonable.

> The power to fix prices whether unreasonably exercised or not involves power to control the market and to fix arbitrary and unreasonable prices. The reasonable price fixed today may through economic and business changes become the unreasonable price of tomorrow. *United States v. Trenton Potteries Co.*, 273 U.S. 392 397, 47 S.Ct. 377, 379 (1927). *See Also United States v. National Ass'n of Real Estate Bds.*, 339 U.S. 485, 488-489, 70 S.Ct. 711, 714 (1950). *Northern California Pharmaceutical Ass'n v. United States*, 306 F.2d 379, 385 (9th Cir.), *cert. denied*, 371 U.S. 862 (1962).

The undisputed facts in this case clearly establish that defendant foundations are combinations which tamper unlawfully with price structures. The very forms on which doctors apply for foundation membership and approve increases in foundation conversion factors are express agreements to fix prices. The foundation conversion factors establish an agreed-upon level for doctors' prices and provide a key for computing uniform prices for every procedure listed in the relative value schedules used by defendants. It makes no difference that defendants call this agreed-upon price level a "maximum" level. The Supreme

Court has clearly established that maximum price agreements are just as *per se* unlawful as other price agreements, since the fixing of maximum prices poses the same unreasonable restraint on competition as the fixing of minimum prices. Because agreements among competitors to fix maximum prices, "..... no less than those to fix minimum prices, cripple the freedom of traders and thereby restrain their ability to sell in accordance with their own judgment [,]" the Supreme Court has consistently held maximum price agreements to be *per se* unlawful under section 1 of the Sherman Act. *Kiefer-Stewart Co. v. Joseph E. Seagram and Sons, Inc.*, 340 U.S. 211, 213, 71 S.Ct. 259, 260 (1951). *Accord, Albrecht v. Herold Co.*, 390 U.S. 145, 88 S.Ct. 869 (1968); *United States v. McKesson & Robbins*, 351 U.S. 305, 76 S.Ct. 937 (1956).

The Supreme Court's recent decision in *National Society of Professional Engineers v. United States*, _____ U.S. _____, 98 S.Ct. 1355, 1365-1366 (1978); clarifies the legal standard applicable to defendants' conduct. In *Professional Engineers*, the Court was presented with a professional society's "ethical rule" against competitive bidding. The defendant society had argued through protracted litigation that its ban on competitive bidding was justified because price competition by engineers could be detrimental to the public welfare. Characterizing defendants' arguments as a fundamental misunderstanding of antitrust analysis, the Supreme Court ruled that the society's ban on competitive bidding was unlawful on its face because, while it was not price fixing as such, "no elaborate industry analysis [was] required to demonstrate the anticompetitive character of such an agreement." *Id.*, 98 S.Ct. at 1365. Since the ban "impede[d] the ordinary give and take of the marketplace,' and substantially deprive[d] customers of the 'ability to utilize and compare prices in selecting engineering services[,]' " the Court held that the agreement on its face restrained trade within the meaning of section 1 of the

Sherman Act. *Id.*, 98 S.Ct. at 1365-1366. Under this legal standard, the price agreements and price schedules of the defendant foundations are clearly *per se* violations of section 1 of the Sherman Act.

Indeed, the agreed-upon use of relative value schedules alone constitutes a *per se* violation of the Sherman Act under the *Professional Engineers* standard. No elaborate industry analysis is required to demonstrate the anticompetitive impact of defendants' use of relative value schedules as uniform pricing manuals. The anticompetitive effect of that practice is amply demonstrated by defendants' price surveys and ballots on price increases, for only the collective use of the relative value schedule makes it possible for defendants to fix the prices of thousands of doctor's services by circulating six numbers on a postcard. Used as a uniform price key by defendants, relative value schedules serve only to relieve the individual doctor of the burden of individual pricing decisions. The use of such pricing manuals and formulas has consistently been held to violate the Sherman Act. *E.G., United States v. Container Corporation of America*, 393 U.S. 333, 87 S.Ct 510 (1969); *Morton Salt Co. v. United States*, 235 F.2d 573 (10th Cir. 1956); *Food & Grocery Bureau of Southern California v. United States*, 139 F.2d 973 (9th Cir. 1943). In recent years, numerous consent judgments have been entered enjoining doctors' associations from using relative value schedules. *E.g., United States v. Illinois Podiatry Society, Inc.*, 1977-2 CCH Trade Cas. ¶ 61,767, at 73,170 (N.D. Ill., 12/6/77; *Federal Trade Commission v. Minnesota Medical Ass'n.*, FTC File No. 771 0028, 3 CCH Trade Reg. Rep. ¶21,236, at 21,186 (4/20/77); *Federal Trade Commission v. American College of Radiology*, FTC File No. 761 0059, 3 CCH Trade Reg. Rep. ¶21,236, at 21,134 (11/17/76); *Federal Trade Commission v. American College of Obstetricians and Gynecologists*, FTC File No. 761 0043, 3 CCH Trade Reg. Rep. ¶21,171, at 21,082 (7/17/76); *Federal Trade Commission v. American Academy of Orthopedic Surgeons*, FTC File No. 761 0058, 3 CCH Trade Reg. Rep. ¶21,171, at

21,082 (7/16/76). Nevertheless, defendants have not only continued to use agreed-upon relative value schedules, but have proceeded to update and maintain in Arizona fee schedules which are subject to consent decrees elsewhere and to develop a new relative value schedule for Arizona doctors. This flagrant violation of the antitrust laws in the face of repeated warnings of illegality cannot be justified or condoned under the rule of *Professional Engineers.*)

Furthermore, the price agreements and consultations regarding desirable relative values and conversion factors which have typically preceded increases in the foundation fee schedules also violate the Sherman Act, since they impede the ordinary give and take of the marketplace and deprive persons seeking medical care of the benefits of price competition. *United States v. Container Corporation of America,* 393 U.S. 333, 89 S.Ct. 510 (1969); *United States v. Utah Pharmaceutical Ass'n.,* 201 F. Supp. 29, 34-35 (D. Utah), *aff'd per curiam,* 371 U.S. 24, 83 S.Ct. 119 (1962); *Phelps Dodge Refining Corp. v. Federal Trade Commission,* 139 F.2d 393 (2d Cir. 1943). In *United States v. Container Corporation of America, supra,* the Supreme Court held that reciprocal exchanges of price information violated the Sherman Act even when no agreement had been made to adhere to any specific price, because each defendant had a manual with which it could compute its competitor's prices. Thus, defendants' regular price surveys, consultations and agreements with foundation members and numerous doctors' associations regarding their collective use of agreed-upon relative value schedules and conversion factors are clearly in violation of the Sherman Act.

The Supreme Court has made it unmistakably clear that members of the so-called "learned professions" are subject to the same antitrust scrutiny as anyone else. *National Society of Professional Engineers v. United States,* _____ U.S. _____, 98 S.Ct. 1355,1367 (1978); *Goldfarb v. Virginia State Bar,* 421 U.S. 773, 787-88, 95 S.Ct. 2004, 2013-

14 1975). The rule of law applicable to professional group activities which impede the setting of price by free market forces was restated in the clearest possible terms in *Professional Engineers:*

> Price is the "central nervous system of the economy," and an agreement that "interfere[s] with the setting of price by free market forces" is illegal on its face. 98 S.Ct. at 1365 (Citations omitted).

Defendants' undisputed use of agreed-upon relative value schedules and unit conversion factors unquestionably interferes with the setting of price by free market forces. Under the holding of *Professional Engineers*, their ongoing conspiracy to fix and stabilize the prices charged by doctors in the State of Arizona is unlawful on its face.

B. Defendants' Use of Agreed-Upon Relative Value Schedules and Conversion Factors Constitutes a Per Se Violation of the Uniform State Antitrust Act.

Arizona Revised Statutes Annotated § 44-1402 prohibits any "contract, combination or conspiracy between two or more persons in restraint of, or to monopolize, trade or commerce," any part which is within the State of Arizona. The Arizona Legislature specifically provided in Arizona Revised Statutes Annotated § 44-1412 that federal case law interpreting the federal antitrust statutes should be used as a guide in construing the Uniform State Antitrust Act, so that a consistent body of case law will be developed under the Uniform Act. Thus, the standards enunciated by the Supreme Court in applying the Sherman Act also apply to defendants' conduct under the Uniform State Antitrust Act. *Cf., Sherman v. Transamerica Title Ins. Co.*, 580 P.2d 729 (Ariz. App. 1978). Under those standards, defendants' actions are *per se* violations of the Uniform State Antitrust Act as well as the Sherman Act. Indeed, the strong public interest favoring a competitive marketplace which has been

enunciated by the federal courts is underscored in the State of Arizona by the constitutional protection against price-fixing and other restraints of trade which has been provided in the Arizona Constitution. Ariz. Const. art. 14 § 15.

C. Even If Defendants' Conduct Were Subject To Rule of Reason Analysis, It Would Clearly Be In Violation of Section 1 of the Sherman Act and the Uniform State Antitrust Act.

In the *Professional Engineers* decision the Supreme Court determined that the defendant society's arguments to the effect that competition by professionals was not in the public interest had been based upon "a fundamental misunderstanding of the Rule of Reason." 98 S.Ct. at 1360. The Court ruled that arguments about the merits of competition in a profession, *id.* at 1367-1368, or the purported benefits of monopolistic arrangements, *id.* at 1364, were simply not cognizable under the Sherman Act. Clarifying the legal standard to be applied under the Rule of Reason, the Court said:

> [T]he inquiry mandated by the Rule of Reason is whether the challenged agreement is one that promotes competition or one that suppresses competition. *Id.* at 1365.

While this legal standard is more lenient than the *per se* rule which applies to price-fixing and other agreements having clear anticompetitive impact, it would still mandate a determination that defendants' use of agreed-upon price schedules is in violation of section 1 of the Sherman Act and the Uniform State Antitrust Act.

III. CONCLUSION

The Supreme Court's ruling in *National Society of Professional Engineers v. United States* is dispositive of this case. Defendants' undisputed use of agreed-upon relative value schedules and conversion factors to set doctors' prices is, to a far greater extent than a professional rule against competitive bidding, an agreement which " 'impedes the

ordinary give and take of the marketplace,' and substantially deprives customers of the 'ability to utilize and compare prices in selecting [professional] services.'" 98 S.Ct. at 1365-1366. Under the clear standards enunciated in *Professional Engineers,* the horizontal pricing agreements among doctors which the undisputed facts in this case establish are on their face restraints of trade within the meaning of section 1 of the Sherman Act and the Uniform State Antitrust Act. Although these price-fixing agreements fall within the *per se* rule, they would also be deemed unlawful under the Rule of Reason standard enunciated by the Supreme Court, because they have suppressed price competition by establishing and maintaining a uniform pricing system for Arizona doctors. Since there is no dispute on any material fact and defendants can raise no defense for their conduct that is cognizable under the Sherman Act, plaintiff is entitled to the entry of partial summary judgment in its favor and against defendants that defendants' actions are in violation of the Sherman Act and the Uniform State Antitrust Act. *International Salt Co. v. United States,* 332 U.S. 392, 68 S.Ct. 12 (1947).

DATED this 20th day of November, 1978.

(Signatures omitted in printing.)

Filed - DEC 7, 1978
W. J. Furstenau, Clerk
U. S. District Court
For The District of Arizona

RESPONSE TO PLAINTIFF'S MOTION FOR PARTIAL SUMMARY JUDGMENT ON THE ISSUE OF LIABILITY

The defendant, Pima Foundation for Medical Care, hereby enters its opposition to the plaintiff's Motion for Partial Summary Judgment on the issue of liability and adopts as its memorandum in support thereof its memorandum heretofore filed in opposition to Plaintiff's Motion for Partial Summary Judgment on the Issue of Subject Matter Jurisdiction.

The essentials of this defendant's opposition to both Motions are contained in that memorandum, which is adopted for this purpose by this reference.

Respectfully submitted,

(Signature omitted in printing.)

Filed - DEC 7, 1978
W. J. Furstenau, Clerk
U. S. District Court
For The District of Arizona

(Caption omitted in printing.)

OPPOSITION TO PLAINTIFF'S MOTION FOR PARTIAL SUMMARY JUDGMENT ON THE ISSUE OF SUBJECT MATTER JURISDICTION

The defendant Pima Foundation for Medical Care responds to the Attorney General's Motions for Summary Judgment as follows:

The Attorney General of the State of Arizona has alleged that defendant, Pima Foundation for Medical Care has violated federal antitrust law. The Attorney General does *not* allege, nor is there evidence tending to prove, that the Pima Foundation has imposed mandatory uniform fee schedules on doctors who practice within Pima County. Hence, this case does not fall within the rule announced in *Goldfarb v. Virginia State Bar*, 421 U.S. 773, 95 S.Ct. 2004 (1975). That Court observed:

> "A purely advisory fee schedule issued to provide guidelines, or an exchange of price information without a showing of actual restraint on trade, would present us with a different question." (Citations omitted.) 421 U.S., at p. 781.

The Sherman Act does not prohibit the gathering of average cost information within a trade or profession, even though some uniformity of pricing may result. *Cement Mfgrs. Protective Association v. United States*, 268 U.S. 588, 45 S.Ct. 586 (1924); *Maple Flooring Mfg. Association v. United States*, 268 U.S. 563, 45 S.Ct. 586 (1924).

Plaintiff Mr. Goldfarb was able to prove that the Bar Association's minimum fee schedule was more than an exchange of average price information. It was mandatory, given that any attorney who habitually charged less than the minimum schedule was presumed to be "guilty of misconduct." (Id. at p. 778). He also demonstrated actual

"restraint on trade," in that all of the 37 attorneys that he contacted in Fairfax County, Virginia, refused to examine the title for less than the local fee schedule.

In contrast, the Attorney General has not alleged that the Pima Foundation has imposed mandatory fee schedules on doctors. Nor has the Attorney General introduced any evidence that the Foundation has the power to set uniform fees for all doctors in the County, or that it has attempted to do so.

Rather, the Attorney General alleges that the Pima Foundation has fixed uniform fees with respect to three health insurance policies written by three major insurance carriers. Thus, the essence of the Complaint is that this defendant, *through the medium of three independent health insurance carriers,* has conspired to fix prices for covered health services. The heart of the Attorney General's Complaint, then, is that this defendant has conspired to set the rates for *health insurance payments* to Pima County doctors. Since health insurance is substantial business in this State and throughout the United States, the Attorney General asserts that this alleged local price fixing of *health insurance* payments ripples into the health industry generally and across state lines.

However, even if the Attorney General could prove the jurisdictional and substantive claims relevant to federal antitrust violation, the very nature of the Complaint and the facts of this case fall within the "business of insurance" exemption. The controlling statue, known as the McCarran Act, provides that the Sherman, Clayton and Federal Trade Commission Acts:

> "... shall be applicable to the business of insurance to the extent that such business is not regulated by State law." 15 U.S.C. §1012(b).

There can be no question that the Pima Foundation is "regulated by State law." as evidenced by the attached letter from the State of Arizona Department of Insurance. (See Exhibit "A") This letter, dated October 30, 1978, is addressed to the Pima Foundation for Medicare (sic) Care and states the following:

> "It has come to the attention of this Department that the functions your organization perform are those of an Insurance Administrator as defined under the Arizona Revised Statute Section 20-485 (et seq). You are therefore required to comply with this law by obtaining from this Department a Certificate of Registration. For your convenience we are enclosing the necessary forms."

A.R.S. § 20-485 is applicable to the Pima Foundation in that it processes claims for health insurance, for which it receives a six per cent management fee. (See the attached affidavit of Mr. Finley, Exhibit "B.") The Foundation does not collect premiums.

Thus, the Pima Foundation falls squarely within the statutory language as an "Insurance Administrator" in that it processes claims for payment and sets maximum rates for various categories of covered health services.

The Attorney General ignores the fact that the Foundation-approved health insurance plans do not require participation of all doctors, nor does it preclude any doctors from payment for services rendered to Foundation-approved policyholders.

Policyholders are not required to see only those doctors who are members of the Foundation. It may be to the advantage of the policyholder to see a Foundation doctor, who has agreed that his charges will not exceed the *ceiling* rates established by the Foundation. On the other hand, if the policy-holder receives medical service from a doctor who is

not a member of the Foundation, the Foundation will pay the same amount as to a Foundation doctor—but the policy holder must be responsible for any excess charge assessed by the non-Foundation doctor. (See Exhibit "B.")

Thus, the Foundation-approved plans represent the effort of the private medical community to control rising health costs. It does this by setting maximum rates which *the Foundation* will pay to given specialists for given medical tasks. It in no way interferes with the choice of patients or doctors.

If a policyholder happens to be traveling out-of-state and has a need for health care, the Foundation will reimburse the out-of-state doctor at the same rates as a Foundation doctor. However, the policyholder is responsible to that non-Foundation doctor for any part of his charge which exceeds the Foundation maximum. The number of such out-of-state payments from the Pima Foundation is minimal. All of the doctors and all of the policyholders in the three Pima Foundation-sponsored plans are residents of Pima County. (See Exhibit "B.") This minimal amount of out-of-state payments is insufficient to invoke Federal jurisdiction. The United States Supreme Court disposed of the same question in *Oregon State Medical Society, supra;*

> "... The Government did show that Oregon Physicians Service made a number of payments to out-of-state doctors and hospitals, presumably for treatment of policyholders who happened to remove or temporarily be away from Oregon when need for service arose. These were, however, few, sporadic and incidental." (Id. at pp. 338-339.)

Thus, the Foundation sponsorship of health plans underwritten by three private carriers represents *new competition* in the local health insurance market. As in

Oregon State Medical Society, supra, the Foundation's entry into the field of prepaid medical care makes it another one of several "competitors in the field." (Id., at pp. 334-335.)

It is important to note that *Oregon State Medical Society* is not inconsistent with *Goldfarb,* in that the latter involved the setting of minimum fees for all attorneys within the State of Virginia. Furthermore, *Goldfarb* involved examination of titles of property prior to sale, a mandatory function with obvious interstate ramifications as to foreign buyers and lenders.

In contrast, *Oregon State Medical Society* involved a group of doctors who associated for the purpose of entering the prepaid medical field. As such, their prepaid plans tended to increase competition among existing health insurance policies. In so doing, these prepaid medical plans did not interfere in the choices made by doctors and patients.

Mr. Goldfarb had no choice but to pay the mandatory minimum fee if he wanted to buy property, whereas the policyholders in *Oregon State Medical Society* and in the present case have the added choice of another competitor health plan.

BREADTH OF THE "BUSINESS OF INSURANCE" EXEMPTION

The "business of insurance" exemption from federal antitrust jurisdiction is one of considerable breadth, and is not affected by whether or not there is a conflict between Federal and State regulation on material issues. *Proctor v. State Farm Mutual Auto Ins. Co.,* 561 F.2d 262 (D.C., 1977).

The "business of insurance" exemption is effective even if the State is lax in regulating those engaged in any of the many facets of insurance. The mere existence of State regulatory machinery is all that is required for the McCarran Act exemption to come into play. *Proctor, supra; Ohio AFL-CIO v. Insurance Rating Board,* 451 F.2d 1178 (6th

Cir., 1971), cert. den. 409 U.S. 917. The breadth of the exemption was discussed in *Dexter v. Equitable Life Assurance Society of U.S.*, 527 F.2d 233 (2d Cir., 1975) in the following terms:

> "The McCarran-Ferguson Act clearly contemplates that where a state undertakes to regulate the business of insurance, it has the power to permit practices which would otherwise violate federal antitrust laws; if the exemption is only to apply when state law squarely prohibits all acts which would, absent the exemption, violate the antitrust laws, the state regulation which the McCarran-Ferguson Act aims to foster, 15 U.S.C., §§ 1011, 1012(a), would be a nullity." (Citations omitted.) 527 F.2d, at p. 236.

Prior to 1943, the common law held that interstate insurance transactions were not "interstate commerce." However, the United States Supreme court re-read the existing statutory definition of "in commerce" jurisdiction and found that interstate insurance transactions were "in commerce." *United States v. South-Eastern Underwriters Ass'n.*, 322 U.S. 533, 64 S.Ct. 1162 (1943).

In response to the holding of *South-Eastern*, Congress added a statutory exception to the "in commerce" jurisdiction as regards state-regulated insurance activity. The McCarran Act, 15 U.S.C., §1011, et seq., reinstated the common law principle that state regulation of the "business of insurance" should generally be unhampered by federal regulation of "interstate commerce." This statute is in harmony with the recent holding in *National League of Cities v. Usery*, 426 U.S. 833, 96 S. Ct. 2465 (1976), which narrowed the reach of "in commerce"jurisdiction where direct state activity was involved. As noted by the Attorney General in the present case, congressional determination of

an issue (such as the exemption of the "business of insurance" from federal antitrust jurisdiction) "merits great deference in this forum." (See the Attorney General's Motion for Partial Summary Judgment, p. 3, lines 23-26.)

The present case is similar to *Proctor, supra,* which was an antitrust action brought by four automobile repair shops against five insurance carriers. The complaint alleged that the five insurance carriers conspired to fix the prices of claims settlements, and that such price fixing was based upon standardized labor rates. The plaintiffs also alleged that the defendants furthered a group boycott favoring certain auto repair shops while disfavoring plaintiffs' repair shops. The favored repair shops complied with the carrier-imposed formula for computation of claims.

The United States District Court granted summary judgment to the defendants on the ground that the conduct of defendants fell within the McCarran Act "business of insurance" exemption. The Court of Appeals affirmed, citing the following language of the District Court with approval:

> "[The] activities complained of in this suit have a vital impact on rate-making and must, of necessity, be included within the term 'business of insurance.' . . . The 'business of insurance' can touch relationships between insurance companies and non-policyholders such as automobile repair shops *when such relationships are closely connected with the insurer-insured relationship through the profound effect of the costs of damage claims in the rate making structure."* Emphasis in Court of Appeals' Opinion, 561, F.2d, at p. 269.)

The plaintiffs argued that the "core" of their case was the horizontal agreement to pay an insured's claim on the basis of the standard formula, based upon standardized labor rates. The District Court and the Court of Appeals found, as a matter of law, that this "core" of defendant's activity fell squarely within the "business of insurance" exemption. (Id. at p. 267.)

The principal difference between *Proctor* and the present case is that the former involved the repair of automobiles whereas the latter involves the diagnosis and treatment of human ailments. Both plaintiffs have alleged a horizontal price-fixing conspiracy, with the standard rate based upon uniform labor rates. In the present case, the uniform maximum fee schedule is drawn in part from a physician's Relative Value Schedule. (See Exhibit "B.")

The relationship of the insurer-repair shop in *Proctor* is analgous to the relationship of the Foundation-doctor in this case. Both relationships are directly connected" ... through the profound effect of costs of damage claims in the rate making structure." (Id., at p. 269)

To similar effect was the facts and holding in *Manasen v. California Dental Services*, 424 F. Supp. 657 (1976). In that case, a nonprofit corporation was in the business of operating prepaid dental care plans. This corporation actually underwrote the actuarial risk that the premium payments would be sufficient to defray the cost of services.

The corporation used the same formulas to calculate premiums as the health insurance carriers used. The United States District Court found that this corporation was engaged in the "business of insurance" and was therefore exempt from federal antitrust jurisdiction.

The case law is replete with many other examples of different kinds of insurance activity falling within the McCarran Act exemption, e.g., *Prudential Insurance Co. v. Benjamin*, 328 U.S. 408, 415-418, 66 S.Ct. 1142; *North Little Rock Transp. Co., Inc. v. Casualty Reciprocal Exchange*, 181 F.2d 174 (5th Cir., 1950); *Lawyers Title Company of Missouri v. St. Paul Title Insurance Corporation*, 526 F.2d 795 (8th Cir., 1975).

This is not to say that the "business of insurance" exemption will protect an antitrust violator where the connection between the violator's conduct and the "business of insurance" is superseded by a dominant federal

policy. See *SEC v. National Securities, Inc.*, 393 U.S. 453, 89 S.Ct. 564 (1969) (an insurance company's relationship to its stockholders is governed by SEC regulations, even though the company is in the "business of insurance").

Furthermore, the "business of insurance" exemption will not apply where the plaintiff can prove "boycott," "coercion" or "intimidation." See *Frankford Hospital v. Blue Cross of Greater Philadelphia*, 554 F.2d 1253 (3d Cir., 1977); *Travelers Insurance Co. v. Blue Cross*, 481 F.2d 80 (3d Cir., 1973); *Doctor's Inc. v. Blue Cross*, 557 F.2d 1001 (3d Cir., 1976).

One example of a "boycott" case is *Royal Drug Co. v. Group Life & Health Ins. Co.*, 556 F.2d 1375 (5th Cir., 1977), which is distinguishable from the present case. In that case, the insurer essentially promulgated a list of "approved" pharmacists which policyholders were to patronize for their prescription drug needs. The insurer reimbursed these "approved" pharmacists at a higher rate than the rate for "non-approved" pharmacists. This discrimination tended to operate as a boycott against the "non-approved" pharmacists, and hence was outside the legitimate "business of insurance" exemption.

In the present case, the Foundation-approved health insurance plans do not have an "approved" list of doctors, pharmacists or anything else. The Foundation-approved plans pay the same amounts up to a maximum for comparable service or drugs to any doctor, regardless of whether or not he is a Foundation member. The same is true of reimbursement to pharmacists: All are treated equally. Hence, the facts of this case do not fall within the *Royal Drug Co.* rule for "boycott," "coercion" or "intimidation." (See Exhibit "B")

In summary, the Pima Foundation is engaged in the "business of insurance" and is regulated by the State Department of Insurance, by their own admission (Exhibit "A"). Therefore, the McCarran Act eliminates federal antitrust jurisdiction. *Proctor, Ohio AFL-CIO, Dexter, Mana-*

sen, Oregon State Medical Society, Benjamin, North Little Rock Transp. Co., Lawyers Title Company of Missouri, supra.

NO "CONDUCT IN COMMERCE" OR "AFFECTING COMMERCE"

The Attorney General has gone to great lengths to introduce evidence that the health care industry is sizeable and that many of the transactions cross state lines. (See the Statement of Undisputed Facts attached to Plaintiff's Motion for Partial Summary Judgment.) Defendant Pima Foundation for Medical Care does not dispute the size and extent of the national health care industry. However, these facts are of no legal significance with respect to the issue of federal subject matter jurisdiction over these defendants.

The Attorney General's position is in harmony with *United States v. South-Eastern Underwriters Ass'n.*, 322 U.S. 533, 64 S.Ct. 1162 (1943). As noted previously, that case changed the common law concept that the "business of insurance" was peculiarly a state-regulated activity. However, shortly after the *South-Eastern* decision, Congress changed the statutory jurisdictional rules with the McCarran Act and reinstated the "business of insurance" exemption from federal antitrust jurisdiction. The United States Supreme Court has had numerous opportunities to overturn the McCarran Act in the past three decades, but has not done so. The only possible conclusion is that the "business of insurance" exemption is still viable.

These defendants have shown that their conduct falls within the "business of insurance" exemption as interpreted by the Courts. See *Proctor, Ohio AFL-CIO, Dexter, Manasen, Oregon State Medical Society, Benjamin, North Little Rock Transp. Co., Lawyers Title Company of Missouri, supra.* Furthermore, the Attorney General's evidence contains not even the suggestion that these defendants entered into any "boycott," coercion" or "intimidation."

Rather, the evidence shows that the State of Arizona Department of Insurance considers the Foundation an "Insurance Administrator" under relevant statutes (See Exhibit "A").

However, even if the State did not regulate the "business of insurance," or even if the conduct complained of was not within the McCarran Act exemption, the Attorney General has still failed to show that these defendants are either "in commerce" or that they have had an "effect on commerce." *Hospital Building Co. v. Trustees of Rex Hospital*, 425 U.S. 738, 96 S.Ct. 1848 (1976); *Gulf Oil Corp. v. Copp Paving Co.*, 419 U.S. 186, 95 S.Ct. 392 (1974).

Much of the Attorney General's evidence as to "in commerce" or "effect on commerce" relates to the conduct of individual doctors, hospitals and pharmacists. No one can deny that these providers of health care service and products do make purchases in interstate commerce. However, the Attorney General is not seeking injunctive and declaratory relief against them in their individual capacities. The Attorney General has named as defendants the Pima County Medical Society, the Pima Foundation for Medical Care, and two counterpart entities in Maricopa County.

The only relevant evidence or discussion has to do with acts done by the Foundation as an individual entity, not by members of organizations acting in their individual capacities. The fact that individual members of an organization engage "in commerce" does not necessarily mean that the organization also engages "in commerce." *Page v. Work*, 290 F.2d 323, 328 (5th Cir., 1961).

The Attorney General also suggests that federal "presence" in the health care industry automatically means that any provider of health care service must also be "in commerce." (See Memorandum of Law In Support of Plaintiff's Motion for Partial Summary Judgment, pp. 3-4) If this theory were correct, the "in commerce" clause would not

only be broadly construed, it would be unbounded. There is federal "presence" in almost every sphere of legal activity, to greater or lesser extent. However, federal "presence" does not equate with "in comme. ·e" jurisdiction.

A similar argument was pressed by the unsuccessful plaintiff in *Copp Paving, supra.* Defendants *Gulf Oil, Union Oil* and others were heavily engaged in producing liquid petroleum for the Los Angeles and Orange County highway construction markets. A substantial portion of their product was used in the construction of the interstate highway system in the Los Angeles area. The Court noted that Congress had passed the Federal Aid Highway Act, 23 U.S.C., §101, et seq., and specifically stated that interstate highways were critical to the national economy.

In addition, there was case law holding that the interstate highways were instrumentalities of commerce, and that employees engaged in the "production of goods for commerce" were within the Fair Labor Standards Act. *Allstate Construction Co. v. Durkin,* 345 U.S. 13, 73 S.Ct. 565 (1953). Notwithstanding these statutes and decisions, the Court found:

> "... No intention to apply the full range of antitrust laws to persons who, as part of their local business, supply materials used in construction of local segments of interstate roads." (419 U.S., at p. 197)

The practice of the healing arts is local in character. *Spears Free Clinic and Hospital for Poor Children v. Cleere,* 197 F.2d 125, 126 (10th Cir., 1952). The fact that the Foundation approves a minimal amount of payments to out-of-state doctors, who treat Foundation policyholders away from Arizona when services are needed, is insufficient to either be "in commerce" or "affect commerce." *Oregon State Medical Society,* 343 U.S. 326, 338-339, 72 S.Ct. 690 (1952).

or is it sufficient to note that Foundation policyholders premiums to out-of-state insurance carriers, or that ı carriers reimburse the Foundation based on 6% of .e premiums. Both Gulf Oil Company and Union Oil ıpany had interstate dealings with their 100% owned ıidiaries who were charged with price-fixing. The *Copp ing* Court rejected the theory that interstate companies ion Oil and Gulf Oil) were automatically "in commerce" n their 100% owned subsidiaries supplied products for l segments of interstate highways. The Court gave the ›wing reason:

The chain of connection has no logical endpoint. The niverse of arguably included activities would be broad nd its limits nebulous in the extreme." (Id., at p. 198)

'he position taken by the Attorney-General in the pre- : case presses upon the Court a chain of connection ch has "no logical endpoint." The mere "presence" of ›ral statutes in the health industry cannot automatically fer "in commerce" jurisdiction over local health provi- ; any more than federal highway statutes or labor .utes convey automatic "in commerce" jurisdiction over ion-dollar oil companies competing in sizeable local ·kets. The Court further observed:

The plaintiff must allege and prove that apparently ›cal acts in fact have adverse consequences on inter- tate markets and the interstate flow of goods in order ›o invoke federal antitrust prohibitions. See *United ›tates v. Yellow Cab Co.*" (Citations omitted) (Id., at 02)

t is undisputed that all 400 doctors in the Foundation l all 6,000 policyholders are residents of Pima County, l that the Foundation restricts its operations to Pima ınty in the State of Arizona. (See Exhibit "B.")

'he fact that some patients come from out-of-state to be ıted by doctors in Arizona is totally irrelevant to the duct of these defendants. The Foundation has no con- l over what price Foundation or non-Foundation doctors

charge non-Foundation patients. The contract between the Foundation and its member doctors is completely silent as to the member doctor's dealings with non-Foundation patients, such as tourists from another state.

This contract does fix a price limit on the doctor's charge to Foundation policyholders. (A limitation for covered charges is common in health insurance policies. Without it, health insurance carriers would be totally at the mercy of doctors and patients.) It should be pointed out that the contract does not require the doctor to charge anything at all to a Foundation policyholder. If he so desires, the doctor could treat the patient for nothing, or for less than maximum rate. The Foundation contract merely sets a maximum limit on the charge for covered services, based upon the nature of the service and the doctor's specialization.

Since the Foundation is located in Pima County, all of the member doctors are located in Pima County, and all of the policyholders reside in Pima County, it is wholly a local matter what prices are charged. Out-of-state patients are treated according to the doctor's own pricing policy, whatever that may be. The Foundation has no pricing policy for out-of-state patients or for in-state patients who are not policyholders in Foundation sponsored plans.

In jurisdictional terms, the relationship between Foundation doctors and policyholders is similar to the relationship between local taxi drivers and local residents. *United States v. Yellow Cab Co.*, 332 U.S. 218, 67 S.Ct. 1560 (1946). In that case, Chicago taxi companies held licenses which specifically restricted their service "between any two points within the corporate limits of the City." (332 U.S., at pp. 230-231) When a local passenger would leave his home, board a cab, and then travel to a city railway station to embark on interstate business, the cab ride from the passenger's home to the terminal was held to be *outside* of the stream of interstate commerce. Likewise, when a resident returned to Chicago by train, boarded a cab from the ter-

minal, and traveled to his home, that ride was also *outside* interstate commerce. The Court held that "such transportation is too unrelated to interstate commerce to constitute a part thereof within the meaning of the Sherman Act." (Id., at p. 230)

However, if an interstate passenger on a train boarded the same cab to travel the short distance between one interstate terminal to another, that trip was held to be within the stream of commerce. (Id., at p. 228)

Therefore, even though a Foundation policyholder visited a Foundation doctor before leaving the state or immediately upon returning to the state, the doctor-patient relationship would be totally based within the state.

Since the entire conduct of the Foundation is centered in its member doctors and its policyholders—all of whom are residents of Pima County—where is the adverse effect on interstate commerce that the Attorney General must prove? *Copp Paving, supra.* Given that only one percent of the population of Pima County is covered by a Foundation-sponsored health plan, any effect would be *de minimus.* The maximum rates of health care payment would certainly not interfere with interstate travel in any reasonable way. *Heart of Atlanta Motel, Inc. v. United States,* 379 U.S. 241, 85 S.Ct. 348 (1964).

The Foundation does not, as a corporate entity, purchase any drugs or medical supplies, or wield any influence on individual doctors and pharamcists as to their purchases in interstate commerce. Since the Attorney General has not named these individual doctors and pharmacists as defendants, the allegation that the Foundation "affects" commerce through purchase of such supplies is without evidentiary foundation.

LOCAL ACTIVITIES WHICH "AFFECT COMMERCE"

The Attorney General has cited a number of cases where local activity had an adverse "effect" upon interstate commerce. These cases are distinguishable from the present case.

The Attorney General repeatedly cites *Rex Hospital, supra,* for the proposition that local health care activity may have a substantial effect on interstate commerce. Before considering the factual differences between *Rex Hospital* and the present case, it should be noted that the lower Court dismissed the original complaint on the pleadings. On remand, the United States Supreme Court stated:

> "We have held that 'a complaint should not be dismissed for failure to state a claim unless it appears beyond doubt that the plaintiff can prove no set of facts in support of his claim which would entitle him to relief' . . . And in antitrust cases, where 'the proof is largely in the hands of the alleged conspirators' . . . dismissals prior to giving the plaintiff ample opportunity for discovery should be granted very sparingly . . ." (Citations omitted.) 425 U.S., at pp. 746-747.

Therefore, the Court did not rule on the factual merits of the case, but held that the complaint was sufficient under several theories to state a cause of action. (In the present case, the Attorney General has had ample opportunity for discovery and has introduced evidence.)

The plaintiff, Hospital Building Company, was a private company which desired: (1) to relocate Mary Elizabeth Hospital to a site within Raleigh, N.C., and (2) to expand its size from 49 to 140 beds. Defendant Rex Hospital, also located in Raleigh, attempted to block Hospital Building's application for a state permit to relocate and expand. After

a long delay, the permit was granted, after which Rex Hospital allegedly engaged in frivolous litigation and maliciously published adverse information about Mary Elizabeth Hospital's proposed expansion.

Thus, an existing provider of health service in the city, Rex Hospital, attempted to *completely foreclose* the efforts of a competitor from moving into the same geographical area and from thereafter tripling in size.

If Rex Hospital succeeded in foreclosing this relocation and expansion, Hospital Building Company would not have purchased as many medical supplies, borrowed as much money, or served as many patients—allegedly from out-of-state.

Since the trial court dismissed the complaint on its pleadings, Hospital Building Company had no opportunity to present admissable *evidence* as to the actual "effect" on commerce. In weighing the dismissal on the pleadings, the United States Supreme Court properly assumed that such "effect" could have been shown by the plaintiff.

Since the present proceeding is one in Summary Judgment, the Court has the benefit of the Attorney General's evidence as to "adverse effect on interstate commerce." There is no showing of interstate lending activity which has been foreclosed by defendant's conduct. Nor has the Attorney General shown how the Foundation may have adversely affected the interstate flow of drugs, medical supplies or patients.

The Foundation has done nothing to *foreclose* the health care industry in Pima County, or any part of it, nor has there been any evidence that competition has been other than benefitted by the addition of new prepaid health plans with unique controls over major expense items.

Rex Hospital did not involve the McCarran Act or the "business of insurance" exemption, nor did the competing hospitals even claim the "business of insurance" exemption.

Even if the McCarran Act was applicable, the remand of *Rex Hospital* would be fully consistent with its "boycott," "coercion" and "intimidation exceptions." Defendant Rex Hospital mounted an attempted total boycott of the proposed relocation and expansion of Mary Elizabeth Hospital, and attempted to coerce and intimidate Mary Elizabeth Hospital, its prospective patients and customers.

The Attorney General has cited other cases where local activity was held to "affect" interstate commerce. In each of these decisions, the defendants were guilty of conduct which could be equated with "boycott," "coercion" or "intimidation."

For example, *Goldfarb* involved a total boycott by the Virginia State Bar against any attorney who would charge a title examination fee lower than the Bar-approved minimum: that attorney, would be presumed to be "guilty of misconduct." The minimum fee schedule also acted to coerce property buyers, since it was virtually impossible to buy property without the title examination, and only Virginia lawyers had legal authority to do the work. *Goldfarb* did not address the McCarran Act or the "business of insurance" exemption.

The same is true of *United States v. Employing Plasterers Assoc.*, 347 U.S. 186, 74 S.Ct. 452 (1953). Chicago plastering contractors and labor unions, who controlled 60% of the plastering market in the area, combined to *prevent* out-of-state contractors from doing business in the Chicago area. The Foundation has not acted to prevent any health provider or insurer from entering the competing in the local market.

Mandeville Island Farms v. American Crystal Sugar Company, 334 U.S. 219, 68 S.Ct. 996 (1948) involved a conspiracy by local sugar refiners against local sugar beet growers. The refiners were the *only* market for the buyers, thus, the refiners were able to intimidate and coerce the growers to accept the refiners' pricing formula.

The same pattern emerged in other cases cited by the Attorney General, e.g., *DeVoto v. Pacific Fidelity Life Insurance Co.*, 516 F.2d (9th Cir., 1975) (a Transamerica loan company and a Transamerica insurance company eliminated a competitor insurance company from a sizeable portion of the California mortgage market); *Gough v. Rossmoor*, 487 F.2d 373 (9th Cir., 1973) (a Rossmoor land developer and a Rossmoor retailer of carpets and drapes combined to exclude a private retailer of furniture, carpets and drapes from a Rossmoor residential development); *Las Vegas Merchant Plumbers Ass'n. v. United States*, 210 F.2d 732 (9th Cir., 1954) (a plumbing association established a committee to allocate bids; wholesalers and laborers who did not comply were boycotted by the remainder of the association); *Boddicker v. Arizona State Dental Association*, 549 F.2d 626 (9th Cir., 1977) (the state and local dental associations coerced its member dentists to also be members of the American Dental Association, even though a dentist in Arizona could practice his profession without joining any of them).

The Foundation has done none of the things which would place them in this line of cases. The Foundation treats Foundation and non-Foundation doctors alike. All pharmacists and hospitals are treated alike.

CONCLUSION

The Sherman Act is "aimed at substance rather than form." *United States v. Yellow Cab Co.*, 332 U.S., at p. 227. Mere exchange of average price information does not run afoul of antitrust prohibitions, even if some uniformity of pricing results. *Cement Mfgrs., Maple Flooring Mfgrs., supra*. The fact that Foundation-sponsored health policies

contain *maximum* prices may appear to have the "form" of a conspiracy in restraint of trade does not mean that such a conspiracy exists in "substance."

The State of Arizona, through its Department of Insurance, has admitted that the Foundation is an "Insurance Administrator" under Arizona law. (Exhibit "A") Therefore, even if the Attorney General could prove the merits of its case, the McCarran Act "business of insurance" exemption would eliminate federal jurisdiction. 15 U.S.C., § 1012(b); *Oregon State Medical Society, Proctor, Page, Ohio AFL-CIO, Dexter, Usery, Manasen, Benjamin, North Little Rock Transp. Co., Lawyers Title Company of Missouri, supra.*

Even if the "business of insurance" ememption was inapplicable to this case, the Attorney General has failed to submit evidence that this defendant was "in commerce" or "affected commerce." *Oregon State Medical Society, Yellow Cab Co., Copp Paving Co., supra.* The 400 doctors who are members of the Foundation serve approximately 6,000 residents of Pima County, or little more than one percent of the County's population.

Communication of average price information across state lines is insufficient to create federal jurisdiction. *Cement Mfgrs., Maple Flooring Mfgrs., supra.* The transfer of funds across state lines, even between a parent corporation and its wholly-owned subsidiary, is insufficient to confer federal jurisdiction. See *Copp Paving, supra.*

There being no material issues as to the facts upon which federal jurisdiction are based, the Motions of the Attorney General should be denied, and the Complaint dismissed against this defendant, as prayed in its Answer here.

(Signatures omitted in printing.)

EXHIBIT "A" OMITTED IN PRINTING

(Caption omitted in printing.)

AFFIDAVIT

STATE OF ARIZONA } ss.
County of Pima }

THOMAS P. FINLEY, being first duly sworn, deposes and says:

1. I am the Executive Director of the Pima Foundation for Medical Care, a position which I have occupied since February, 1978. I reside at 9035 Bears Path Road in Tucson, Arizona.

2. I have personal knowledge of the day-to-day operations of the Pima Foundation for Medical Care ("Foundation"), including its dealings with the Pima County Medical Society ("Medical Society"), the State of Arizona Department of Insurance and various outside parties such as insurance brokers and carriers involved in Foundation sponsored health plans.

3. The Foundation was formed in 1971 by the Medical Society. Its primary purpose was to offer a competitive health plan to help control the rapid increase in the cost of health care within Pima County. In 1978, the Foundation became independent of the Medical Society, which no longer has the right of approval over the selection of Directors for the Foundation.

4. Of approximately 1300 doctors in Pima County, some 400 doctors are members of the Foundation. Several Foundation-sponsored plans provide prepaid health insurance coverage to 6,000 men, women and children in Pima County, or little more than 1% of the total population (500,000) of the County. All of the member doctors and all of the policyholders are residents of Pima County. The 6,000

policyholders, if evenly dispersed among all 1,300 doctors, would amount to 4 or 5 patients per doctor. Spread among the 400 Foundation doctors, these 6,000 policyholders amount to roughly 15 patients per doctor.

5. The Medical Society has nothing whatever to do with Foundation-sponsored claim processing or with the setting of any premium rates or claim payment rates. Nor does the Medical Society have any authority over its 1,300 doctors with respect to what prices they charge in their individual practices, nor has it attempted to wield such authority.

6. Neither the Foundation nor the Medical Society have any formal connection with counterpart organizations in Maricopa County. The prepaid health plans sponsored by the Foundation is independent of any other organization. Any contact with other organizations has been casual and in a discussion of common concerns, but no conspiracy to fix prices has or will be entered into.

7. Most or all of the 400 members of the Foundation are also members of the Medical Society. However, neither the Foundation nor the Medical Society attempt to control the individual decisions of each doctor as to affiliation in either organization or as to policies adopted by either organization. An individual doctor may become affiliated with the Foundation, may decline to affiliate, or may change a previous decision. Membership in each organization is a matter of personal choice, and neither organization applies any direct or indirect pressure on the individual doctor.

8. Approximately 900 doctors in Pima County have not joined the Foundation. Since February, 1978, I have personally been told by a number of these non-participating doctors that they will not join because they feel the rates established by the Foundation are *too low, unreasonable and unfair.*

9. In view of its stated goal to help control the rising cost of health care, the Foundation and its sponsored plans have implemented the following control procedures:

(a) Since a large part of health cost dollars are consumed by long and sometimes unnecessary hospital confinements, the Foundation has adopted a formal program to review *every* instance of a policyholder being sent to the hospital. The Foundation employs a trained nurse who visits every policyholder while in the hospital, and certifies that there was medical justification for the admission and for the projected length of stay. To the best of my knowledge and belief, no other health plan in Pima County provides such comprehensive scrutiny of this major factor in cost of medical care.

(b) The Foundation acts as the claims agent for the private insurance carriers who actually underwrite the risks. Each claim is carefully reviewed to assure that the reimbursement for doctor's fees, medicine and hospital services do not exceed the *maximum* rates established by the Foundation.

10. The Foundation does not discriminate among doctors, pharmacists, hospitals or other suppliers of health care services and products. A policy holder may select a Foundation doctor or a non-Foundation doctor. The only possible difference is that the non-Foundation doctor has not contractually agreed to charge no more than the ceiling rate for his services. Thus, if a policyholder receives medical care from a non-Foundation doctor, he will be personally liable for any excess in charge by that doctor over the Foundation's maximum rate.

11. The Foundation does not discriminate between in-state doctors or out-of-state doctors. If a policyholder happens to be outside Arizona when the need for health care arises, the Foundation will process the claim for covered health items the same as for any other non-Foundation doctor who is located within Arizona. However, the fact remains that the 6,000 policyholders receive covered medi-

cal services from out-of-state doctors only a negligible number of times each year. The policyholder remains liable to that doctor for any charge that is in excess of the Foundation maximums.

12. The Foundation does not discriminate in any way against any hospital, pharmacist or other supplier of coveredf health services. The choice is wholly left up to the patient-policyholder. The Foundation's goal is simply to see that certain portions of covered expenses are insured, no matter which provider of health care (doctor, hospital, pharmacist) the policyholder selects.

13. According to my best information and belief, the presence of the Foundation's prepaid health plans covering approximately one percent of the population of Pima County tends to *increase competition* among health care providers and insurers. The controls which the Foundation exercises over the necessity of *each* hospital stay, together with rigid review of billings against Foundation *maximum rates*, tends to reduce the cost of health care for the 6,000 policyholders.

14. Three private carriers underwrite the various Foundation-sponsored plans, i.e., Arizona Blue Cross-Blue Shield, Pacific Mutual Life Insurance Company, and Connecticut General Life Insurance Company. Each of the Foundation's plans are rated retrospectively. In other words, the savings achieved by the Foundation's hospital review procedure, preliminary scrutiny and review for compliance with rate maximums—these savings are passed along to the policyholder in the subsequent year, once the carrier's overhead expenses are deducted.

15. The Foundation is a nonprofit corporation. It does not collect premiums or actually underwrite the risks, but it does act as the claims agent for the three private insurance carriers who underwrite the risks. These carriers, which are regulated by the State of Arizona, reimburse the Foundation for its cost-control services and claims payment. The reimbursement is calculated at 6% of monthly premiums

received by the carrier. The Foundation has no control over premiums charged by the carriers, other than the effective cost-savings measures that are reflected in lower premiums as the carriers retrospectively rate each plan's experience with loss.

16. The Foundation does exercise direct control over the establishment of maximum payment rates for medical services. However, these rates are a *ceiling*, not a *floor*, for Foundation members. Each doctor who is a member of the Foundation expressly agrees that covered expenses will be reimbursed at no more than the maximum rate established by the Foundation.

17. The Foundation rates are based upon the nature of the medical service rendered and the particular specialization of the doctor performing the service. The rates are set, in part, based upon a Relative Value Schedule and a Unit Conversion Factor.

18. The Foundation's Board of Directors weighs the various factors from industry sources and from their own experience in recommending a rate schedule. After its initial determination, the Board recommends the overall rate schedule to the Foundation's membership. The recommendation becomes effective after a majority of the 400 members approve it. Such payment schedules are reviewed every year or so.

19. The Foundation originally designed its health insurance plan, then contacted an insurance broker to find carriers who would provide the desired coverage. A unique feature in the contracts with the carriers is that the Foundation will perform cost-control review of hospitalization and review all charges against the ceiling rates.

20. Neither the Foundation or the Medical Society purchase any drugs or any medical products, but a minimal amount of office supplies are purchased each year. Doctors, in their individual capacities, do purchase drugs or medical products, or prescribe the same for their patients. The

Foundation has no control or concern over which particular drugs or products are thus favored by individual doctors, nor does the Foundation exercise or attempt to exercise such control with respect to individual pharmacists or hospitals. Thus, the price of drugs and medical supplies in Pima County and elsewhere is totally unrelated to the operation of the Foundation.

21. Based upon my personal knowledge, the Pima Foundation for Medical Care is concerned with the rising cost of medical care in Pima County. Inasmuch as these costs cannot be controlled in various circumstances without some kind of uniform cost ceilings, the Foundation has sponsored several prepaid health insurance plans to implement such maximum rates, and to eliminate unnecessary hospital stays by tight scrutiny from within the medical profession itself.

(Signature and notarization
omitted in printing.)

Filed - DEC 11, 1978
W. J. Furstenau, Clerk
U. S. District Court
For The District of Arizona

(Caption omitted in printing.)

RESPONSE OF DEFENDANT MARICOPA COUNTY MEDICAL SOCIETY TO PLAINTIFF'S MOTION FOR PARTIAL SUMMARY JUDGMENT ON THE ISSUE OF LIABILITY

Defendant Maricopa County Medical Society hereby opposes the plaintiff's Motion for Partial Summary Judgment on the Issue of Liability filed herein upon the grounds and for the reasons set forth in the Memorandum in Response to that Motion filed by Defendant Maricopa Foundation for Medical Care.

Respectfully submitted this 11th day of December, 1978.

(Signature omitted in printing.)

Filed - DEC 11, 1978
W. J. Furstenau, Clerk
U. S. District Court
For The District of Arizona

(Caption omitted in printing.)

DEFENDANT MARICOPA COUNTY MEDICAL SOCIETY'S RESPONSE TO PLAINTIFF'S STATEMENT OF UNDISPUTED MATERIAL FACTS ON ITS MOTION FOR PARTIAL SUMMARY JUDGMENT ON THE ISSUE OF LIABILITY

Most of the factual allegations contained in Plaintiff's Statement of Facts are directed to either the Maricopa or Pima Foundations for Medical Care. Defendant Maricopa County Medical Society is without sufficient knowledge to form a belief as to the truthfulness of the allegations contained in those statements of facts, and is therefore unable to controvert them.

1. Defendant Maricopa County Medical Society denies that it published a Foundation fee schedule (see General Objection No. 1 and Answer to Nos. 59 and 60 of Defendant Maricopa County Medical Society's Responses to Plaintiff's First Request for Admissions and Interrogatories).

2. Defendant Maricopa County Medical Society is unable to discern the meaning or relevance of Plaintiff's Statement No. 38, and therefore denies the same.

(Signature omitted in printing.)

Filed - DEC 12, 1978
W. J. Furstenau, Clerk
U. S. District Court
For The District of Arizona

(Caption omitted in printing.)

DEFENDANT MARICOPA FOUNDATION FOR MEDICAL CARE'S STATEMENT OF MATERIAL FACTS AS TO WHICH THERE IS A GENUINE ISSUE PRECLUDING PARTIAL SUMMARY JUDGMENT IN FAVOR OF THE PALINTIFF ON THE ISSUE OF SUBJECT MATTER JURISDICTION

Defendant Maricopa Foundation for Medical Care ("Maricopa Foundation") submits, pursuant to Local Rule 11(h), this statement of material facts which preclude partial summary judgment in favor of the plaintiff on the issue of subject matter jurisdiction.

A. Maricopa Foundation disputes plaintiff's contention that the following paragraphs of "Statement of Undisputed Facts Supporting Plaintiff's Motion for Partial Summary Judgment on the Issue of Subject Matter Jurisdiction" are not disputed:

1. With respect to Plaintiff's Statement 1, doctors in Maricopa County have not agreed to be bound by a fee schedule adopted by members of Maricopa Foundation. The only determinations with respect to fees charged for medical services which are made by Maricopa Foundation are with respect to maximum fees paid with respect to patients covered by Maricopa Foundation endorsed plans to member doctors of Maricopa Foundation. They have agreed to accept Maricopa Foundation's determination of maximum fees as payment in full for services performed by them on patients covered by Foundation endorsed plans when they billed the patient more than that amount. If the patient is billed less than that amount, the physician is paid the amount billed if the services are determined by Maricopa Foundation to have been medically appropriate. Maricopa Foundation does not and never has taken any

position with respect to the amount of fees a physician should bill any patient. (*See, e.g.*, Mitten Aff., November 17, 1978, paras. 3, 4.)

2. Maricopa Foundation has no information sufficient to admit or deny Plaintiff's Statement 2.

3. With respect to Plaintiff's Statement 3, Maricopa Foundation has entered into agreements with insurers Pacific Mutual Life Insurance Company, Washington National Life Insurance Company, Connecticut General Life Insurance Company, Metropolitan Life Insurance Company, Northwestern National Life Insurance Company, Cal Western Insurance Company, and Occidental Life Insurance Company, all of which transact business in Arizona wherein insurers agreed to reimburse doctors for services rendered to patients insured under Maricopa Foundation-endorsed health insurance plans in accordance with the their usual and customary fees charged for such services but not to exceed the maximum reimbursable level of compensation set forth in the Maricopa Foundation's minimum standards for Foundation-endorsed group insurance programs, except at the insurer's discretion. Maricopa Foundation has no information sufficient to admit or deny Plaintiff's statement with respect to Pima Foundation or other defendants. (*See, e.g.*, Response 12 of Defendant Maricopa Foundation for Medical Care's Responses to Plaintiff's First Request for Admissions and Interrogatories.)

4. Maricopa Foundation for Medical Care has no information sufficient to admit or deny Plaintiff's Statement 4.

5. Maricopa Foundation for Medical Care has no information sufficient to admit or deny Plaintiff's Statement 5.

6. Maricopa Foundation has no information sufficient to admit or deny Plaintiff's Statement 6.

7. Maricopa Foundation denies that the payment of premiums, claims and service fees on Maricopa Foundation endorsed insurance plans has involved a continuous stream of fee schedules, claims and continuous transfers of sub-

stantial sums of money across state lines and states it has no information sufficient to admit or deny the remainder of Plaintiff's Statement 7.

8. Maricopa Foundation denies that underwriting and operation of Maricopa Foundation endorsed insurance plans have involved a continuous stream of fee schedules, agreements, policies, claims and other materials and services across state lines and states it has no information sufficient to admit or deny the remainder of Plaintiff's Statement 8.

9. With respect to Plaintiff's Statement 9, if a patient insured under a Maricopa Foundation endorsed plan seeks treatment from a doctor outside the state of Arizona, the Foundation will pay the claim in the same manner as any claim for services performed by a doctor. Claims paid on Maricopa Foundation endorsed health insurance plans to out-of-state doctors are very few in number. Maricopa Foundation has no information sufficient to admit or deny Plaintiff's statement with respect to Pima Foundation. (*See*, Mitten Aff., December 11, 1978, para. 7.)

10. With respect to Plaintiff's Statement 10, the relative value schedules prepared and used by Maricopa Foundation are based in part upon the 1964 edition of the Relative Value Schedule adopted by the California Medical Association, in part upon the Relative Value Schedules adopted by the American Society of Anesthesiologist, and in part upon the Relative Value Schedules adopted by the American College of Radiology. Maricopa Foundation has no information sufficient to admit or deny Plaintiff's statement with respect to Pima Foundation, Pima Society, or Maricopa Society. (See, Responses 19, 21, and 23 of Defendant Maricopa Foundation for Medical Care's Responses to Plaintiff's First Request for Admissions and Interrogatories.)

11. With respect to Plaintiff's Statement 11, Maricopa Foundation has requested various professional organizations whose members are doctors to advise Maricopa Foundation only in connection with Maricopa Foundation's

determination of maximum reimbursable levels of compensation to doctors providing medical services to patients insured under Maricopa Foundation endorsed health insurance plans to be proposed to Maricopa Foundation's participating and cooperating members for adoption. Maricopa Foundation has no information sufficient to admit or deny Plaintiff's statement with respect to Pima Foundation, Pima Society, or Maricopa Society. (See, Responses 44 through 53 of Defendant Maricopa Foundation for Medical Care's Responses to Plaintiff's First Request for Admissions and Interrogatories.)

12. With respect to Plaintiff's Statement 12, Maricopa Foundation denies it obtained fee schedules and materials related to fee schedules through interstate association with other foundations for medical care. Maricopa Foundation has no information sufficient to admit or deny Plaintiff's statement with respect to Pima Foundaon, Pima Society, or Maricopa Society. (See, Mitten Aff., December 11, 1978, para. 4.)

13 With respect to Plaintiff's Statement 13, officers and employees of Maricopa Foundation have traveled to other states for meetings with representatives of other foundations for medical care for two purposes:

1. To study the claims processing operations used by other medical foundation; and,

2. To promote the foundation concept of health insurance.

No officer or employee of Maricopa Foundation has met with the representative of another medical foundation to discuss or to take any action with respect to fees charged for medical services by doctors in Arizona. (See, Mitten Aff., December 11, 1978, para. 4.)

14. With respect to Plaintiff's Statement 14, Maricopa Foundation has received only one grant from the federal government. The amount of the grant was less than $100,000.00 and its purpose was to study the desirability

and feasibility of Maricopa Foundation forming a Health Maintenance Organization. That study was not related to the functions performed by Maricopa Foundation as a medical foundation and no changes in the operations of Maricopa Foundation took place as a result of that study. Maricopa Foundation has no information sufficient to admit or deny Plaintiff's statement with respect to Pima Foundation. (See, Mitten Aff., December 11, 1978, para. 5.)

17. Maricopa Foundation has no information sufficient to admit or deny Plaintiff's Statement 17 with respect to the amounts of prescription drugs, equipment, goods and products which are manufactured and distributed in other states and shipped into Arizona.

18. Maricopa Foundation has no information sufficient to admit or deny Plaintiff's Statement 18 with respect to the amount of money paid annually for services, goods and products sold by doctors within the state of Arizona.

19. Maricopa Foundation has no information sufficient to admit or deny Plaintiff's Statement 19 with respect to the portion of the prices charged by the doctors in the State of Arizona which are paid through private health insurance.

20. Maricopa Foundation has no information sufficient to admit or deny Plaintiff's Statement 20 with respect to the amount paid by the state of Arizona for health insurance premiums in 1977.

21. Maricopa Foundation has no information sufficient to admit or deny Plaintiff's Statement 21 with respect to the number of persons in Arizona who had insurance protection against medical expenses or surgical expenses in 1975.

22. Maricopa Foundation has no information sufficient to admit or deny Plaintiff's Statement 22 with respect to the amount of premiums paid for private health insurance in Arizona.

23. Maricopa Foundation has no information sufficient to admit or deny Plaintiff's Statement 23.

24. Maricopa Foundation has no information sufficient to admit or deny Plaintiff's Statement 24.

25. Maricopa Foundation has no information sufficient to admit or deny Plaintiff's Statement 25.

B. Maricopa Foundation incorporates herein by reference the facts set forth in the affidavits of Anthony D. Mitten, sworn to November 17, 1978 and December 11, 1978, which set forth material facts precluding summary judgment in favor of plaintiff. December 11, 1978

(Signatures omitted in printing.)

(Caption omitted in printing.)

AFFIDAVIT OF
ANTHONY D. MITTEN

STATE OF ARIZONA }
} ss.
County of Maricopa }

ANTHONY D. MITTEN, being duly sworn, under oath deposes and says:

1. I am the Executive Director of defendant Maricopa Foundation for Medical Care ("Maricopa Foundation") and have been its chief administrative employee since its inception. I make this affidavit in opposition to plaintiff's motions for partial summary judgment on the issues of subject matter jurisdiction and liability and to supplement my affidavit sworn to November 17, 1978 which is incorporated herein by reference. I have personal knowledge with respect to the matters related in this affidavit.

2. The sole purpose for which relative value schedules and conversion factors have been prepared or used by the Maricopa Foundation is in determining the maximum reimbursable levels of compensation for medical services provided to those patients insured under Maricopa Foundation endorsed medical health insurance plans. The Maricopa Foundation does not publish or distribute relative value schedules or conversion factors used by the Foundation to non-members except to insurers who may be interested in underwriting Maricopa Foundations endorsed health insurance plans and persons eligible for membership in Maricopa Foundation who have expressed an interest in joining the Maricopa Foundation.

3. Conversion factors used by Maricopa Foundation to determine the maximum reimbursable levels of compensation for medical services provided to patients insured under Maricopa Foundation endorsed medical health insurance plans are revised when it is felt by Maricopa Foundation's Board of Trustees that they have fallen so far below usual

and customary fees in Maricopa County that doctors will resign from or refuse to renew membership in Maricopa Foundation if the conversion factors are not revised. Revision of those conversion factors is not conducted at any regular interval. The Maricopa Foundation has surveyed its members with respect to the fees they usually and customarily charge for their services on only two occasions. On both occasions the survey was conducted to aid Maricopa Foundation's Board of Trustees in determining whether to revise the maximum reimbursable levels of compensation for medical services provided to patients insured under Maricopa Foundation endorsed medical health insurance plans and the nature of the revisions which the Board of Trustees would submit to the participating and cooperating members of Maricopa Foundation for their approval. On three other occasions such revisions have been submitted to participating and cooperating members for their approval without any such survey.

4. Officers and employees of Maricopa Foundation have traveled to other states for meetings with representatives of other foundations for medical care for two purposes: (1) to study the claims processing operations used by other medical foundations; and (2) to promote the Foundation concept of health insurance. At no time, to my knowledge, has any officer or employee of Maricopa Foundation met in another state with a representative of another medical foundation or an association of doctors to discuss or take any action with respect to fees charged for medical services by doctors in Arizona.

5. The Maricopa Foundation has received only one grant from the Federal Government. The amount of the grant was less than $100,000 and its purpose was to study the desirability and feasibility of Maricopa Foundation forming a

Health Maintenance Organization. That study was not related to the functions performed by Maricopa Foundation as a medical foundation and no changes in the operations of Maricopa Foundation took place as a result of that study.

6. To the best of my knowledge, information and belief, at no time has the Board of Trustees of Maricopa Foundation recommended to the membership or the membership of Maricopa Foundation approved a maximum reimbursable level of compensation for medical services provided to patients insured under Maricopa Foundation endorsed medical health insurance plans in excess of what Maricopa Foundation's Board of Trustees believed to be the prevailing average or median usual and customary fee charged by doctors in Maricopa County for their services.

7. Virtually all of the member doctors of the Maricopa Foundation and almost all of the policyholders insured under Maricopa Foundation endorsed health insurance plans are residents of Maricopa County, Arizona. The vast majority of claims paid on Maricopa Foundation endorsed health insurance plans are paid to Arizona doctors for services rendered in Arizona. Claims paid on Maricopa Foundation endorsed health insurance plans to out-of-state doctors are very few in number.

8. The Maricopa Foundation does not purchase any drugs, medical equipment, goods or products. Maricopa Foundation does not have or exercise any control over the particular drugs, medical equipment, goods or products purchased by doctors, pharmacists or hospitals or the prices charged by them for drugs or medical products, equipment or goods. To the best of my knowledge, information and belief, the prices paid for drugs and medical products in Maricopa County and elsewhere are not affected in any way by the operation of Maricopa Foundation.

9. To the best of my knowledge, information and belief, at no time has Maricopa Foundation taken any action to request, urge or even suggest that a doctor increase the fee charged to any patient or taken any action with respect to

any doctor as a result of any fee charged by a doctor to any patient, other than to bring to the attention of the Arizona Board of Medical Examiners, those instances in which, in the opinion of the Board of Trustees of Maricopa Foundation, the fee charged by a doctor is so excessive as to constitute unprofessional conduct pursuant to A.R.S. § 32-1451.

(Signature and notary clause omitted in printing.)

(Caption omitted in printing.)

AFFIDAVIT OF
GARY L. SWINGLE

STATE OF ARIZONA }
} ss.
County of Maricopa }

GARY L. SWINGLE, being duly sworn, under oath deposes and says:

1. I am an associate of the law firm of Brown & Bain, P.A., attorneys for defendant Maricopa Foundation for Medical Care ("Maricopa Foundation"). I make this affidavit in support of Maricopa Foundation's Motion for Order Compelling Discovery.

2. In support of its motion for a preliminary injunction, plaintiff compared graphically "the relationship between foundation fee schedules and the payments made by the Industrial Commission of Arizona since 1970 for medical and anesthesiological services." Memorandum in Support of Application for Order to Show Cause and Motion for Preliminary Injunction dated October 25, 1978 at pp. 6-7. In opposing Maricopa Foundation's Motion for Order Compelling Discovery, plaintiff states "... that memorandum refers only to payments made by the Industrial Commission," not to relative value schedules, unit conversion factors, or fee schedules used or referred to by the Industrial Commission and therefore, the discovery sought by Maricopa Foundation is "completely irrelevant to any issue in this lawsuit." Plaintiff's Response to Defendant Maricopa Foundation for Medical Care's Motion for Order Compelling Discovery dated December 8, 1978 at p. 5.

3. The Industrial Commission of Arizona is charged by law with the responsibility to fix a schedule of fees to be charged by physicians attending injured employees, which shall be reviewed annually by the Commission. A.R.S. § 23-908. Pursuant to this charge, the Industrial Commission of Arizona publishes a "MEDICAL FEE SCHEDULE." An-

nexed hereto as Exhibit A is a true copy of the first 38 pages and Appendix I of "Medical Fee Schedule Adopted by the Industrial Commission of Arizona" dated December 1, 1970 ("Arizona Industrial Commission Fee Schedule"). On information and belief the Arizona Industrial Commission Fee Schedule is currently used by the Industrial Commission of Arizona to determine payments made by it and fees charged by physicians attending injured employees.

4. On information and belief, the Arizona Industrial Commission has annually established, pursuant to A.R.S. § 23-908, separate unit values and conversion factors for each of the five sections of the Arizona Industrial Commission Fee Schedule. The Arizona Industrial Commission Fee Schedule contains a relative value schedule divided into four sections: "Medicine," "Surgery," "Radiololgy," and "Laboratory" based on the 1964 California Relative Value Studies, published by the California Medical Association. The Arizona Industrial Commission Fee Schedule states that the Arizona Industrial Comission has approved the American Society of Anesthesiologists' Relative Value Guide (Second edition, 1967) for use with its conversion factor to establish fees for anesthesiology.

5. The opening page of the Arizona Industrial Commission Fee Schedule contains the following statement:

> "This Medical Fee Schedule, with the pertinent conversion factors adopted by The Industrial Commission of Arizona (see "resolution"), establishes the maximum fees that can be charged by physicians and surgeons to insurance carriers or self-insured employers for services performed for employees under workmen's compensation coverage."

6. The Arizona Industrial Commission Fee Schedule specifies that fees are to be calculated in the following manner:

"The amount of fee is to be calculated by multiplying the unit value (listed under the specific code number for a specific procedure) by the conversion factor established for each section in the schedule (see "Resolution"). Formula: Unit Value × Conversion Factor = Fee."

7. At the beginning of each section of the Arizona Industrial Commission Fee Schedule, the following statements appear:

"In billing, the physician must include the Code Number as assigned to the [medical, surgical, radiological, or laboratory] procedure involved and use the Unit Value prescribed by the Industrial Commission to determine his fee. Billing Formula: Unit Value × Conversion Factor = Fee."

8. A comparison of the "payments made by the Industrial Commission" with the maximum insurance reimbursement levels to physicians for services to patients insured under Maricopa Foundation endorsed health insurance reveals that in some instances the Arizona Industrial Commission Fee Schedule provides higher payments to physicians, and in some instances it provides the same payments as the maximum reimbursement rate of Maricopa Foundation endorsed health insurance plans.

9. It is respectfully submitted that the foregoing facts amply demonstrate the relevance to this action of the materials sought by Maricopa Foundation's Motion for Order Compelling Discovery.

(Signature and notary clause omitted in printing.)

95

MEDICAL FEE SCHEDULE

Adopted By

THE INDUSTRIAL COMMISSION OF ARIZONA

PHOENIX, ARIZONA DECEMBER 1, 1970

EXHIBIT A

STATE OF ARIZONA

MEDICAL FEE SCHEDULE for PHYSICIANS

adopted by

THE INDUSTRIAL COMMISSION OF ARIZONA

Bruce C. Thoeny, Chairman

Frank G. Murphy, Vice Chairman

John L. Ahearn, Member

Robert W. Knox, Member

Hugh W. Stewart, Member

December 1, 1970

Robert L. Kley, Director

ORDER OF CONTENTS

Page

A. INTRODUCTORY MATERIAL

Foreward 5

Resolution of The Industrial Commission of Arizona 6

Laws and Rules of Procedure 8-23

Instructions for Physicians 24-31

I. General Information on Treatment 24-26

II. Forms Used by Physicians 27-28

III. Filing of Reports and Claims 29

IV. Check-Off List for Procedures 30-31

B. MEDICAL FEE SCHEDULE ..... arranged by Code Numbers

I. Medicine
II. Surgery
III. Radiology
IV. Laboratory

C. APPENDIX I: ANESTHESIA

D. APPENDIX II: PROCEDURAL INDEX
(by Alphabet with Code Numbers designated)

Because the Industrial Commission has adopted the 1964 California Relative Value Studies as the basis for this schedule of fees, the following statement is in order:

"Portions of the Relative Value Studies are taken from the copyrighted material of the California Medical Association and are reproduced with the permission of the California Medical Association. Grateful acknowledgement is made to them for the use of this information."

It must be stressed, however, that this schedule of fees as such and the conversion factors to be applied thereto are the determination of The Industrial Commission of Arizona.

FOREWORD

In 1925, when the Arizona Legislature passed the State's first Workmen's Compensation Act, The Industrial Commission of Arizona was established to administer that compensation law.

In 1943, industrial insurance coverage was extended by the State under the Arizona Occupational Disease Disability Law to cover certain job-connected diseases.

Thus for 43 years, the Industrial Commission was responsible, both for the administration of these workmen's compensation laws, and for the processing of all claims entered under those laws.

Then in 1968, when the Legislature reorganized the Industrial Commission, the ICA retained its regulatory role, to administer and enforce the laws for insurance coverage of industrial injuries and occupational diseases. Processing of claims for industrial injuries occurring since Jan. 1, 1969, was assigned to the State Compensation Fund and other authorized private insurance carriers. However, the Industrial Commission still retained the responsibility for processing all claims filed before Jan. 1, 1969, as well as no-insurance claims and claims filed under occupational disease disability laws.

As stated in the following Resolution, the Industrial Commission is charged with fixing a schedule of fees to be charged by physicians attending injured employees. The statutes also give the ICA full authority to make rules and regulations reasonably required in the performance of its duties.

Physicians attending employees under industrial insurance coverage are obligated by law to charge according to the schedule of fees herein adopted. Accurate calculation of fees based upon this schedule, the prompt filing of reports

and bills for payment, and the use of forms prescribed are essential to early and correct remuneration for a physician's services and can be vital in the award of benefits to the workman and his dependents.

RESOLUTION

WHEREAS pursuant to the provisions of A.R.S. § 23-908 (1968), The Industrial Commission of Arizona is charged with the responsibility of, and has full power, jurisdiction and authority to fix a schedule of fees to be charged by physicians attending injured employees, which shall be reviewed annually by the Commission, and

WHEREAS, the Commission, after carefully reviewing all material received and developed in order to evaluate the fee schedule for physicians, in its regular meeting on September 15, 1970, unanimously voted to approve the following:

1. Adoption of the 1964 California Relative Value Studies as the basis for the schedule which the Commission will publish to have available on the effective date of December 1, 1970.

2. Continuation of approval of the use of the A.S.A. Relative Value Study as the basis of charges for anesthesia.

3. Conversion factors to be applied to the new schedule effective December 1, 1970:

	CONVERSION FACTOR
(a) Medicine	$ 7.0
(b) Surgery	6.5
(c) Radiology	6.5
(d) Laboratory	6.0
(e) Anesthesia	7.0

NOW, THEREFORE, BE IT RESOLVED that The Industrial Commission of Arizona adopts the schedule of fees presented to it for its consideration at its regularly schedule meeting on October 27, 1970, and that the fees to be charged by physicians attending injured employees shall be in accordance with said schedule of fees, and

BE IT FURTHER RESOLVED that The Industrial Commission of Arizona adopts the following conversion factors to be applied to the schedule of fees herein adopted effective December 1, 1970 and to continue in effect until further action by this Commission:

	CONVERSION FACTOR
(a) Medicine	$ 7.0
(b) Surgery	6.5
(c) Radiology	6.5
(d) Laboratory	6.0
(e) Anesthesia	7.0

DATED at Phoenix, Arizona this 27th day of October, 1970.

APPROVED:

THE INDUSTRIAL COMMISSION OF ARIZONA

By /s/ Bruce C. Theony
Chairman

By /s/ Frank G. Murphy
Member

By /s/ John L. Ahearn
Member

By /s/ Robert W. Knox
Member

By /s/ Hugh W. Stewart
Member

ATTEST: Louise Suter
Secretary

LAWS AND RULES OF PROCEDURE

The following excerpts from the Arizona Revised Statutes and the Rules of Procedure Before The Industrial Commission of Arizona have direct application to physicians attending employees in Arizona who have been injured or incur an occupational disease as the result of and in the course of their employment.

A. GENERAL LAW: A.R.S., TITLE 23 — LABOR

CHAPTER 1. INDUSTRIAL COMMISSION
CHAPTER 6. WORKMEN'S COMPENSATION
CHAPTER 7. OCCUPATIONAL DISEASE DISABILITY

23-921. Administration of chapter

A. The industrial commission of Arizona is charged with the duties of the administration of chapters 6 and 7 of this title, and with the adjudication of claims for compensation arising out of provisions of this chapter and any of its members or assistants so authorized may:

1. Hold hearings at any place within the state or without the state by agreement of the parties.

2. Administer oaths.

3. Issue and serve by the commission's representatives, or by any sheriff, subpoenas for the attendance of witnesses and claimants and the production of reports, papers, contracts, books, accounts, documents and testimony. The commission may require the attendance and testimony of employers, their officers and representatives before any proceeding of the commission, and the production by employees of books, records, papers and documents.

4. Generally provide for the taking of testimony and for the recording of proceedings held in accordance with this chapter.

B. The commission may make and declare all rules and regulations which are reasonable required in the performance of its duties, including but not limited to rules of practice and procedure in connection with hearing and review proceedings. Such rules and regulations may provide for informal prehearing conferences in order to expedite claim adjudication, amicably dispose of controversies, narrow issues and simplify the method of proof at hearings.

C. The commission may incur such expenses as it determines are reasonably necessary to perform its authorized functions, which expenses shall be a charge against the administrative fund.

D. The commission may charge any person with contempt who refuses to comply with any order of the commission, upon application to the superior court. Any person held in contempt may be punished by a fine of not to exceed one thousand dollars.

23-929. Enforcement of chapter

Upon request of the commission the attorney general or under his direction the county attorney of the proper county, shall institute and prosecute the necessary actions or proceedings for the enforcement of the provisions of chapters 6 and 7 of this title, or for any penalty provided for therein, and shall prosecute or defend all actions or proceedings brought by or against the commission, or the members thereof in their official capacity. The commission may compromise any action.

23-932. Violations; penalty

A person who violates any provision of this chapter, commits any act therein prohibited, fails or refuses to perform any duty thereby imposed within the time prescribed by law or by the commission, or fails, neglects or refuses to obey an order of the commission or a judgment of a court made and entered under the provisions of this chapter, for which no penalty or punishment is otherwise specifically

provided, is guilty of a misdemeanor punishable by a fine of not less than fifty nor more than one thousand dollars for the first offense, and not less than one hundred nor more than five thousand dollars for each subsequent offense.

23-1061. Notice of accident; form of notice; application for compensation; reopening; payment of compensation

H. An employee may reopen his claim to secure an increase or rearrangement of compensation or additional benefits by filing with the commission a petition requesting the reopening of his claim upon the basis of new, additional or previously undisovered temporary or permanent condition, which petition shall be accompanied by a statement from a physician setting forth the physical condition of the employee relating to the claim. The payment for such reasonable and necessary medical examination and laboratory work expense shall be paid for by the employer's insurance carrier or the self-insuring employer if it accepts the petition as hereinafter provided. No other additional compensation shall be payable for any period prior to the date of filing of the petition.

23-1125. Violations and penalty

An employer who fails to comply with section 23-1161, or a person who violates any other provision of this chapter, does an act prohibited thereby, or fails or refuses to perform a duty imposed by this chapter within the time prescribed by law or by the commission for which no penalty is specifically provided, or fails, neglects or refuses to obey an order of the commission or a judgment of a court under the provisions of this chapter, is guilty of a misdemeanor punishable by a fine of not less than fifty nor more than one thousand dollars for the first offense, and not less than one hundred nor more than five thousand dollars for each subsequent offense.

23-1270. Processing of prior claims

The commission appointed pursuant to the provisions of chapter 1 of this title shall process all claims for injuries or disabling conditions under chapters 6 and 7 which occur prior to January 1, 1969 to the entry of a final award in accordance with the procedure and benefit levels in effect prior to the effective date of this section. Petitions to reopen filed subsequent to the effective date of this section shall be processed in accordance with the procedural provisions of chapters 6 and 7.

B. INDUSTRIAL INJURIES

23-908. Injury reports by employer and physician; fees of physician; violations; penalty

A. Every employer affected by the provision of this chapter, and every physician who attends an injured employee of such employer, shall file with the commission and the employer's insurance carrier from time to time a full and complete report of every known injury to the employee arising out of or in the course of his employment and resulting in loss of life or injury. Such report shall be furnished to the commission and such insurance carrier at times and in the form and detail the commission prescribes, and shall make special answers to all questions required by the commission under its rules and regulations.

B. The commission shall fix a schedule of fees to be charged by physicians attending injured employees, which shall be reviewed annually by the commission.

C. Information obtained by the attending physician or surgeon while in attendance on the injured person shall not be considered a privileged communication, if such information is requested by interested parties for a proper understanding of the case and a determination of the rights involved.

D. When an accident occurs to an employee, the employee shall forthwith report the accident and the injury resulting therefrom to the employer, and any physician employed by the injured employee shall forthwith report the accident and the injury resulting therefrom to the employer, the insurance carrier and to the commission.

E. When an accident occurs to an employee, the employer may designate in writing a physician chosen by the employer, who shall be permitted by the employee, or any person in charge of the employee, to make one examination of the injured employee in order to ascertain the character and extent of the injury occasioned by the accident. The physician so chosen shall forthwith report to the employer, the insurance carrier and the commission the character and extent of the injury as ascertained by him. If the accident is not reported by the employee or his physician forthwith, as required, or if the injured employee or those in charge of him refuse to permit the employer's physician to make the examination, and the injured employee is a party to the refusal, no compensation shall be paid for the injury claimed to have resulted from the accident. The commission may relieve the injured person or his dependents from the loss or forfeiture of compensation if it believes after investigation that the circumstances attending the failure on the part of the employee or his physician to report the accident and injury are such as to have excused them.

F. Within ten days after receiving notice of an accident, the employer shall inform his insurance carrier. The insurance carrier or self-insurer shall inform the commission on such forms and in such manner as may be prescribed by the commission.

G. Immediately upon notice to the employer of an accident resulting in an injury to an employee, the employer shall provide the employee with the name and address of the employer's insurance carrier, the policy number and expiration date.

H. Any person failing or refusing to comply with the provisions of this section is guilty of a misdemeanor punishable by a fine of not less than fifty nor more than two hundred dollars.

23-1021. Right of employee to compensation

A. Every employee coming within the provisions of this chapter who is injured, and the dependents of every such employee who is killed by accident arising out of and in the course of his employment, wherever the injury occurred, unless the injury was purposely self-inflicted, shall be entitled to receive and shall be paid such compensation for loss sustained on account of the injury or death, such medical, nurse and hospital services and medicines, and such amount of funeral expenses in event of death, as are provided by this chapter.

B. Every employee covered by insurance in the state compensation fund who is injured by accident arising out of and in the course of employment, and the dependents of every such employee who is killed, provided the injury was not purposely self-inflicted, shall be paid such compensation from the state compensation fund for loss sustained on account of the injury, shall receive such medical, nurse and hospital services and medicines, and such amount of funeral expenses in event of death, as provided in this chapter.

23-1026. Periodical medical examination of employee; effect of refusal or obstruction of examination or treatment

A. An employee who may be entitled to compensation under chapters 6 and 7 shall submit himself for medical examination from time to time at a place reasonably con-

* * * *

D. RULES OF PROCEDURE BEFORE THE INDUSTRIAL COMMISSION OF ARIZONA

RULE 1. Notice of Rules; Part of Record; Effective Date

(a) These rules apply to all actions and proceedings of or before the Commission pertaining to claims resulting from injuries which occured on or after January 1, 1969, and to Petitions to Reopen or Petitions for Readjustment or Rearrangement of Compensation filed on or after that date, and shall be deemed a part of the record in each such action or proceeding without formal introduction of, or reference to, the same. All parties are deemed to have knowledge of these rules. A copy of the rules will be supplied upon request to any person free of charge by the Commission. These rules shall become effective on September 1, 1970, and shall apply to all hearings held after October 1, 1970.

(b) These rules supersede all present Rules of Procedure Before The Industrial Commission of Arizona, and all present Rules of Procedure Before The Industrial Commission of Arizona are hereby repealed except for those which affect existing or accrued rights connected with the processing to entry of a final award of claims for injuries or disabling conditions which occurred prior to January 1, 1969, as provided by Arizona Revised Statutes, Section 23-1270.

RULE 2. Location of Office and Office Hours

The main office of The Industrial Commission of Arizona is located in Phoenix, Arizona. An office is also located in Tucson, Arizona. The offices are open for the transaction of business from eight (8) o'clock A.M. until five (5) o'clock P.M. every day except Saturdays, Sundays and legal holidays.

* * * *

RULE 17. Medical, Hospital and Burial Expense

(a) Medical, surgical and hospital benefits shall be in accordance with the various medical and surgical fee schedules adopted by the Commission and in effect at the time the services billed are rendered. Physician, nursing, hospital, drug or other medical bills shall be itemized and presented for payment to the employer, or if he is insured for medical, surgical or hospital benefits, to his insurance carrier. In the event the employee or employer has paid such items, reimbursement shall be made to the person paying same to the extent allowed by the fee schedules provided that receipted vouchers or bills are presented in support of a claim for reimbursement.

RULE 31. Maintenance of Claims File; contents; Inspection and Copying; Exchange of Medical Reports

(a) There shall be maintained at the claims office referred to in Rule 30, a claims file which shall be the repository of all employer's reports, medical and hospital reports, awards, orders, notices of claims status, wage data and all other items required by law to be maintained by the carrier affecting the claim.

(b) The claims file referred to shall be available for inspection and copying, subject to the provisions of subsection (c) hereof, by all interested parties or their authorized representatives to the Industrial Commission proceedings, including representatives of the Industrial Commission. Copies shall be furnished upon request at a charge not to exceed fifteen cents (15¢) per page.

(c) Documents or matters representing the work product of the insurance carrier, or its attorney, investigation and rehabilitation reports shall not be considered subject to inspection and copying as provided in subsection (b) hereof, and need not be maintained in the claims file.

* * * *

IV. CHECK-OFF LIST FOR PROCEDURES IN COMPENSATION CASES

(A copy of this check-off list may prove helpful to the physician as a guide sheet for the file of each workman's compensation case.)

( ) 1. If the employee claimant, at time of first treatment, does not bring an insurance carrier identification form from his employer requesting medical treatment, the physician should promptly check with the employer to determine if the employee was injured on the job, the name of the insurance carrier and the policy number.

( ) 2. At the time of first treatment, the physician should complete, in accurate detail, the "Physician's Initial Report" on Form ICA 102, and assist the employee in completing the upper portion ("Workman's Report") of the same form.

( ) 3. Within *eight* days after first treating the employee, the physician must send copies of the above Form ICA 102 to The Industrial Commission of Arizona, to the employer, and to the insurance carrier.

( ) 4. If the employee remains under medical care for more than seven days, the physician is to submit monthly progress reports (Form ICA 04-0427, or the equivalent) to the insurance carrier of self-insured employer, until his final report that the employee has returned to his job.

( ) 5. In cases where employee's condition warrants his submitting a "Workman's Supplemental Claim for Compensation" (Form ICA 04-0521, or the equivalent), the physician is to complete and sign his portion of that form.

INSTRUCTIONS FOR PHYSICIANS

( ) 6. If the physician releases the employee to "light work," he should make his report to the insurance carrier or self-insured employer, completing and signing the "Workman's Supplemental Claim Form" (Form ICA 04-0521 A, or the equivalent).

( ) 7. The physician's bills calculated according to the fixed medical fee schedules and the conversion factors fixed by the Industrial Commission, shall be submitted, once a month, to the insurance carrier, or the self-insured employer.

( ) 8. If the employee files a petition to reopen his claim on the basis of a new, additional or previously undiscovered disability or condition, the attending physician must submit an accompanying medical report if the petition is to be accepted for consideration (see Rule 33).

( ) 9. In respect to all occupational disease disability cases, the attending physician is to submit all reports and medical bills to the Industrial Commission.

* * * *

MEDICAL FEE SCHEDULE

(Arranged by Code Numbers)

I. Medicine
II. Surgery
III. Radiology
IV. Laboratory

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1. This Medical Fee Schedule, with the pertinent conversion factors adopted by The Industrial Commission of Arizona (see "Resolution"), establishes the maximum fees that can be charged by physicians and surgeons to insurance carriers or self-insured employers for services performed for employees under workmen's compensation coverage.

2. Unit values and conversion factors have been established separately for each of the sections included in this fee schedule: "Medicine," "Surgery," "Radiology," and "Laboratory." Fees to be charged for anesthesia are not listed in this schedule. See Appendix on Anesthesia.

3. The amount of fee is to be calculated by multiplying the unit value (listed under the specific code number for a specific procedure) by the conversion factor established for each section in this schedule (see "Resolution"). Formula: Unit Value × Conversion Factor = Fee.

4. Bills, submitted monthly by the attending physician, must be itemized by the description of procedure, code number, date of service and amount of charge. Any bill which does not contain the code number for the designated procedures will not be paid and will be returned for the necessary information. Each itemized procedure should be coded on a separate line.

5. Routine progress and routine final reports filed by the attending physician do not ordinarily command a fee.

6. Payment will be made for only one professional visit in any one day except when the submitted report clearly demonstrates the need for the additional visit and fee.

7. Fees for hospital, office or home visits, subsequent to the initial visit, are not to be added to coded surgical procedures performed in the same day.

MEDICINE

GENERAL INFORMATION AND INSTRUCTIONS

1. The following visits, examinations, consultations and similar services are the most frequently recurring and widely variable items of medical care. The time requirements of these services range from the briefest possible contact with the patient to the time-consuming interview and exhaustive examination needed to appraise a complex medical problem. The following gradation of services is listed in an attempt to reflect the relative values of the various times and skills required.

2. (†): Those items preceded by a (†) may be used by all physicians, but are to be used when the problem appears to be of a serious or difficult nature requiring additional time and/or special study, e.g., Internal Medicine, Pediatrics, Neurology, etc. Written reports shall be furnished upon request.

3. "Sv." Items: "Sv," in the value column indicates the value is to be calculated as the sum of the various services rendered, (e.g., office, home, nursing home or hospital visit, consultation or detention, etc.) according to the rules covering those services.

4. Medical care of an unusual or unlisted value which represents a type of service over and beyond listed procedures may occur. If substantiated "By Report" (see Rule 5), additional unit values may be warranted.

5. "By Report": When the value of a procedure is to be determined "By Report," information concerning the nature, extent and need for the procedure or service, the time, the skill and the equipment necessary, etc., is to be furnished. A detailed clinical record is not necessary.

6. "Independent Procedure": Certain of the listed procedures are commonly carried out as an integral part of a total service and as such do not warrant a separate charge. When such a procedure is carried out as a separate entity, not immediately related to other services, the indicated value for "Independent Procedure" is applicable.

7. Values for other diagnostic, therapeutic, surgical, x-ray and laboratory procedures are listed in the sections entitled "Surgery," "Radiology" and "Laboratory."

8. Necessary drugs, supplies and materials provided by the physician may be charged for separately.

9. Routine office treatment principally by injections of drugs other than antibiotics requires authorization by the carrier or self-insured employer for each series of 10 after the first series of 10.

10. Consultation must be authorized, except in emergencies, and consultant must render his own report.

11. Attending physician may submit a claim for consultant's fee only when such service is requested by carrier or self-insured employer.

12. Missed individual appointments for consultants, without prior notification, will be compensated at 50 per cent of consultation fee.

In billing, the physician must include the Code Number as assigned to the medical procedure involved, and use the Unit Value prescribed by the Industrial Commission to determine his fee.

Billing Formula: Unit Value × Conversion Factor = Fee

OFFICE VISITS

CODE NUMBER		UNIT VALUE
9000	Initial office visit, routine, new patient or new illness, history and examination	2.0
†9001	Initial (or subsequent) office visit, complete diagnostic history and physical examination, established patient or minor chronic illness, including initiation of diagnostic and treatment programs	3.5
†9002	Initial (or subsequent) office visit, complete diagnostic history and physical examination, new patient or major illness, including initiation of diagnostic and treatment programs	6.0
9003	Follow-up office visit, brief; e.g., routine injection, minimal dressing, etc.	0.8
9004	Follow-up office visit, routine	1.0
†9005	Follow-up office visit necessitating professional care, over and above routine visit	1.5
†9006	Follow-up office visit, prolonged, over and above 9005	2.0
†9007	Follow-up office visit necessitating complete re-examination and re-evaluation of patient as a whole (continuing illness)	3.0
†9008	Re-examination, comprehensive diagnostic history and re-evaluation, established patient, (annual type)	4.0
0001	Special narrative report evaluating status as to temporary or permanent disability, when requested by employer or carrier	3.0

HOME or NURSING (CONVALESCENT) HOME VISITS

9010	Initial home visit, routine, new patient or new illness, history and examination	2.5
†9011	Initial home visit, complete diagnostic history and physical examination, established patient or minor chronic illness, including initiation of diagnostic and treatment programs	4.0
†9012	Initial home visit, complete diagnostic history and physical examination, new patient or major illness, including initiation of diagnostic and treatment programs	7.0
9013	Follow-up home visit, brief; e.g., routine injection, minimal dressing, etc.	1.5
9014	Follow-up home visit, routine	2.0
†9015	Follow-up home visit necessitating professional care, over and above routine visit	3.0

MEDICINE

CODE NUMBER		UNIT VALUE
†9017	Follow-up home visit necessitating complete re-examination and re-evaluation of patient as a whole (continuing illness)	3.5

HOSPITAL VISITS

9020	Initial hospital visit, routine history and physical examination, including initiation of diagnostic and treatment programs and preparation of hospital records	3.0
†9021	Initial hospital visit, complete diagnostic history and physical examination, established patient or minor chronic illness, including initiation of diagnostic and treatment programs and preparation of hospital records	5.0
†9022	Initial hospital visit, complete diagnostic history and physical examination, new patient or major illness, including initiation of diagnostic and treatment programs and preparation of hospital records	6.0
9024	Follow-up hospital visit, routine	1.0
†9025	Follow-up hospital visit necessitating care over and above routine visit	2.0
†9027	Follow-up hospital visit necessitating complete re-examination and re-evaluation of patient as a whole	3.0

CONSULTATIONS

A consultation is considered to denote services rendered by a physician whose opinion or advice is requested in the evaluation and/or treatment of a patient's condition. When the consultant-physician thereupon assumes the continuing care of the patient, any subsequent service rendered by him will no longer be considered as a consultation. If the medical problem necessitates the concurrent services and skills of two or more physicians, each physician will be entitled to the listed values of his service. Second examinations by the consultant in regard to the same or related problem should be billed as visits, and not as consultations unless otherwise authorized.

†9028	Consultation requiring limited examination and/or evaluation of a given system but not requiring a complete diagnostic history and examination, home, office or hospital	3.0
†9029	Consultation requiring more extensive examination and/or evaluation but not requiring complete diagnostic history and examination, home, office or hospital	5.0
†9030	Consultation requiring complete diagnostic history and examination and/or evaluation, office, home or hospital	7.0

MEDICINE

CODE NUMBER		UNIT VALUE
0002	Consultation of unusual complexity (in excess of scope of service identified by 9028, 9029 or 9030) necessitating diagnostic history and examination, extensive review of prior medical records, compilation and assessment of data and the preparation of a special report, home, office or hospital ..... (A higher fee may be allowed if more than three hours are required to complete the consultation.)	10.0 to 15.0
0003	Attendance at operation or autopsy and report of findings when requested by employer or carrier	10.0 to 15.0
0004	Expert opinion and written report without examination, based on a hypothetical case or clinical records, x-rays, laboratory findings, autopsy or other data	7.0 to 14.0
0006	Expert testimony at hearing, per one-half day session: first hour or part thereof ..... each additional hour or part thereof	$50.00 $25.00

IMMUNIZATIONS (UNCOMPLICATED)

9040	Immunization(s), per visit (smallpox vaccination includes reading) ..... (For desensitization to horse serum, etc., see 9415)	1.0

PSYCHIATRIC SERVICES

9050	Psychotherapy, office, hospital or home, verbal, drug augmented or other methods, one hour	5.0
9053	group (maximum 8 persons per group) one and one half hours, per person	1.5
9055	Electroshock (per treatment), sub-convulsive	4.0
9056	convulsive	5.0
9057	Insulin shock (per treatment), sub-coma	4.0
9058	coma	6.0
9059	Metrazol convulsive shock (per treatment)	5.0
9060	Psychometric testing (one hour) with written report	5.0
9064	Inpatient care, prolonged (chronic case)	Sv.

OTHER SERVICES

9070	Mileage, per mile, one way, beyond 10 mile radius of point of origin (office or home) ..... (Within large metropolitan areas, a travel-time basis may be appropriate, by report.)	0.2

CODE NUMBER		UNIT VALUE
†9071	Dentention—Prolonged detention with patient in critical condition requiring constant attention beyond usual service, per hour	5.0
9073	Night Calls: When calls are made between 8:00 p.m. and 8:00 a.m. in response to requests received during those hours, add to listed value for visit	1.0
9074	Services rendered during unusual hours for the patient's convenience may warrant an additional charge.	
9075	Special Reports: (i.e., insurance forms, narrative reports, review of medical records). When information more than that necessary to establish or to clarify a patient's status in requested (e.g., more than the standard reporting form) or a request is made for review of medical records and report, a charge adequate to cover the value of the additional service is justified.	

SPECIFIC DIAGNOSTIC SERVICES

Listed values may be added to other significant services rendered at the same visit.

Values for items 9101 to 9277 include laboratory procedure(s), interpretation and physicians' services (except surgical services as listed in the section on Surgery), unless otherwise stated.

For other similar services, see appropriate sections.

9101	Electrocardiogram with interpretation and report	3.0
9102	tracing only, without interpretation and report	1.5
9103	interpretation and report only	1.5
9104	with exercise test	5.0
9105	tracing only without interpretation and report	2.5
9106	interpretation and report only	2.5
9107	single lead (for rhythm) with interpretation	1.0
9112	Phonocardiogram with interpretation and report	4.0
9113	with indirect carotid artery tracing or similar study	5.0
9115	Vectorcardiogram (VCG), with or without EKG, interpretation and report	5.0
9116	when part of other diagnostic studies	4.0
9120	Venous pressure determination	1.0
9122	Circulation time, per test (not to exceed 2.0 units) (For radioisotope tests, see 7836.)	1.0
9123	Recording of direct arterial pressure tracings (independent procedure) (Recording of intracardiac pressures with evaluation and interpretation included as part of items 2330-2335)	4.0

CODE NUMBER		UNIT VALUE
9126	Cardiac output (Fick) (independent procedure) (excluding cardiac catheterization—see 2330-2335) ..... (For radio-isotope methods, see 7835)	5.0
9127	Dye dilution studies, indicator dye curves	1.0
9128	cardiac output, initial (independent procedure)	5.0
9129	subsequent, same study period, each (independent procedure) ..... (When dye dilution studies are part of right heart catheterization, maximum units allowed will be 18; when part of combined right and left heart catheterization, maximum units allowed will be 22.)	2.5
9150	Arterial puncture to obtain blood specimen	1.5
9151	pH, arterial blood, including puncture	3.0
9152	Blood volume (dye method) including total plasma and blood cell volumes	6.0
9153	pH, venous blood	1.5
9154	Carbon dioxide content (Van Slyke), initial	2.0
9155	subsequent, same study	1.0
9156	Oxygen saturation (Van Slyke), initial	3.0
9157	subsequent, same study ..... (Total same study, not to exceed 11 units.)	1.0
9160	Oxygen saturation (Cuvette), initial	2.0
9161	subsequent, same study ..... (Total same study, not to exceed 5.5 units.)	0.5
9164	Oxygen saturation (ear oximeter) all readings same study	1.5
9168	Oxygen content (Van Slyke), initial	2.0
9169	subsequent, same study ..... (Sum of items 9153, 9154, 9156, 9157, 9160, 9161, 9168 and 9169 when part of one study, not to exceed 20 units)	1.5
9175	Oxygen content and saturation, carbon dioxide content and pH	5.0
9176	pH, pCO^2 and related values (Astrup type), initial (for arterial puncture, see 9150)	3.0
9177	subsequent, each	2.0
9190	Peripheral vascular disease studies	by report
9192	Plethysmography	by report
9193	Temperature gradient studies	by report
9194	Thermogram	by report

APPENDIX I: ANESTHESIA

GENERAL INFORMATION

The code and unit values for anesthesia services are not included in this medical fee schedule. The Industrial Commission has established the conversion factor to be used in determining fees for anesthesia services and has approved the American Society of Anesthesiologists Relative Value Guide (2nd Edition, 1967) as basis for such charges.

1. The total values for anesthesia services include pre- and post-operative visits, the administration of the anesthetic and the administration of fluids and/or blood incident to the anesthesia or surgery.

2. Calculated values for anesthetic services are to be used only when the anesthesia is personally administered by a licensed physician and surgeon who remains in constant attendance during the procedure for the sole purpose of rendering such anesthetic service.

3. If the general or regional anesthetic is administered by the attending surgeon, the value shall be fifty per cent (50%) of the calculated value.

4. In procedures where no value is listed, the basic portion of the calculated value will be the same as listed for a comparable procedure.

5. Necessary drugs and materials provided by the physician anesthetist may be charged for separately.

6. Where unusual detention with the patient is essential for the safety and welfare of such patient, the necessary time will be valued on the same basis as indicated below for anesthesia time.

7. No fee will be allowed for local infiltration or digital block anesthesia administered by the operating surgeon.

8. Anesthesia time starts with the beginning of the administration of the anesthetic agents and ends when the anesthetist is no longer in personal attendance (when the patient may be safely placed under customary post-operative supervision).

Filed - DEC 12, 1978
W. J. Furstenau, Clerk
U. S. District Court
For The District of Arizona

(Caption omitted in printing.)

DEFENDANT MARICOPA FOUNDATION FOR MEDICAL CARE'S STATEMENT OF MATERIAL FACTS AS TO WHICH THERE IS A GENUINE ISSUE PRECLUDING SUMMARY JUDGMENT IN FAVOR OF THE PLAINTIFF ON THE ISSUE OF LIABILITY

Defendant Maricopa Foundation for Medical Care ("Maricopa Foundation") submits, pursuant to Local Rule 11 (h), this statement of material facts which preclude partial summary judgment in favor of the plaintiff on the issue of liability.

A. Maricopa Foundation disputes plaintiff's contention that the following paragraphs of "Statement of Undisputed Facts Supporting Plaintiff's Motion for Summary Judgment on the Issue of Liability" are not disputed:

1. With respect to Plaintiff's Statement 1, the membership of Maricopa Foundation includes medical doctors, osteopaths, podiatrists, and oral surgeons. Maricopa Foundation has no information sufficient to admit or deny plaintiff's statement with respect to Pima Foundation, Pima Society, and Maricopa Society (*See, e.g.*, Exhibit MF-122 to Plaintiff's First Request for Admissions.)

2. With respect to Plaintiff's Statement 2, the only determinations with respect to fees charged for medical services which are made by Maricopa Foundation are with respect to maximum fees paid with respect to patients covered by Maricopa Foundation endorsed plans to the member doctors of Maricopa Foundation. They have agreed to accept Maricopa Foundation's determination of maximum fees as payment in full for services performed by them on patients covered by Foundation endorsed plans when they bill the patient more than that amount. If the patient is billed less than that amount, the physician is paid the amount billed if

the services are determined by Maricopa Foundation to have been medically appropriate. Maricopa Foundation does not and never has taken any position with respect to the amount of fees a physician should bill any patient. (*See, e.g.*, Mitten Aff., Nov. 17, 1978, paras. 3 and 4.)

3. Maricopa Foundation has no information sufficient to admit or deny Plaintiff's Statement 3.

4. With respect to Plaintiff's Statement 4, to determine the maximum reimbursable payment to a doctor for services provided to a patient insured under a Maricopa Foundation endorsed health insurance plan, one must refer both to a relative value schedule and a conversion factor, and peer review determines that the services are medically necessary or appropriate. Maricopa Foundation has no information sufficient to admit or deny plaintiff's statement with respect to Pima Foundation. (*See, e.g.*, Response 17 of Defendant Maricopa Foundation for Medical Care's Responses to Plaintiff's First Request for Admissions and Interrogatories.)

6. With respect to Plaintiff's Statement 6, Maricopa Foundation only uses unit conversion factors to determine the maximum reimbursable level of compensation payable by the insurer to doctors for services provided to patients insured under a Maricopa Foundation endorsed health insurance plan. (Mitten Aff., Nov. 17, 1978, para. 4.)

7. With respect to Plaintiff's Statement 7, the relative value schedules used by Maricopa Foundation are based in part upon the 1964 Edition of the Relative Value Schedule adopted by the California Medical Association, the Relative Value Schedules adopted by the American Society of Anesthesiologists, and the Relative Value Schedules adopted by the American College of Radiology. Maricopa Foundation has no information sufficient to admit or deny plaintiff's statement with respect to Pima Foundation, Pima Society,

or Maricopa Society. (*See, e.g.*, Responses 19, 21, and 23 of Defendant Maricopa Foundation for Medical Care's Responses to Plaintiff's First Request for Admissions and Interrogatories.)

8. With respect to Plaintiff's Statement 8, the Maricopa Foundation has only prepared relative value schedules for use in Arizona to determine the maximum reimbursable levels of compensation payable by the insurer to doctors for services provided to patients insured under Maricopa Foundation endorsed health insurance plans. (Response 29 of Defendant Maricopa Foundation for Medical Care's Responses to Plaintiff's First Request for Admissions and Interrogatories.)

9. With respect to Plaintiff's Statement 9, the Maricopa Foundation has revised its relative value schedules. It has in some instances increased and in some instances decreased the unit value used to determine the maximum reimbursable level of compensation payable by the insurer to doctors for services provided to a patient insured under a Maricopa Foundation endorsed health insurance plan. The sole purpose for which relative value schedules have been prepared or used by the Maricopa Foundation is in determining the maximum reimbursable levels of compensation for medical services provided to those patients insured under Maricopa Foundation endorsed medical health insurance plans. Maricopa Foundation has no information sufficient to admit or deny plaintiff's statement with respect to Pima Foundation, Pima Society, or Maricopa Society. Maricopa Foundation has not publicized and encouraged the use of relative value schedules. (*See, e.g.*, Responses 28 and 32 of Defendant Maricopa Foundation for Medical Care's Responses to Plaintiff's First Request for Admissions and Interrogatories; Mitten Aff., Dec. 11, 1978, para. 2.)

10. With Respect to Plaintiff's Statement 10, Maricopa Foundation's maximum reimbursement levels of compensation to doctors providing medical services to patients insured under Maricopa Foundation endorsed health insurance plans are determined using unit conversion factors for six categories of relative values. (*See, e.g.*, Exhibit MF-63 to Plaintiff's First Request for Admissions; Mitten Aff., Dec. 11, 1978, para. 2.)

11. With respect to Plaintiff's Statement 11, participating and cooperating members of Maricopa Foundation have the right to vote on the adoption of maximum reimbursable levels of compensation to doctors providing medical services to patients insured under Maricopa Foundation endorsed health insurance plans. These votes have been conducted by mail ballot. Maricopa Foundation has no information sufficient to admit or deny plaintiff's statement with respect to Pima Foundation. Maricopa Foundation has not polled its members as to relative value schedules and unit conversion factors they prefer or relative value schedules and unit conversion factors they consider appropriate for Maricopa Foundation. (*See, e.g.*, Response 34 of Defendant Maricopa Foundation for Medical Care's Responses to Plaintiff's First Request for Admissions and Interrogatories.)

12. With respect to Plaintiff's Statement 12, the Maricopa Foundation has on two occasions surveyed its members as to their usual and customary fees for medical services, and as to what conversion factors and relative value schedules they used for the purpose of calculating their usual and customary fees for medical services. (*See, e.g.*, Responses 37 through 43 of Defendant Maricopa Foundation for Medical Care's Responses to Plaintiff's First Request for Admissions and Interrogatories.)

13. With respect to Plaintiff's Statement 13, Maricopa Foundation has on a non-periodic basis requested various professional organizations whose members are doctors to advise Maricopa Foundation in connection with Maricopa

Foundation's determination of maximum reimbursable levels of compensation to doctors providing medical services to patients insured under Maricopa Foundation endorsed health insurance plans to be proposed to Maricopa Foundation's participating and cooperating members for adoption. Maricopa Foundation has not polled them as to relative value schedules and unit conversion factors their members use or prefer or the fees their members usually charge. (*See* Responses 44 through 53 of Defendant Maricopa Foundation for Medical Care's Responses to Plaintiff's First Request for Admissions and Interrogatories.)

14. With respect to Plaintiff's Statement 14, Maricopa Foundation repeats its response to statement 13.

15. With respect to Plaintiff's Statement 15, Maricopa Foundation has only used information obtained from surveys of doctors and from professional organizations to advise Maricopa Foundation's Board of Trustees in connection with its determination of maximum reimbursable levels of compensation to doctors providing medical services to patients insured under Maricopa Foundation endorsed health insurance plans to be proposed to Maricopa Foundation's participating and cooperating members for adoption. Maricopa Foundation repeats its response to plaintiff's statement 13. Maricopa Foundation has no information sufficient to admit or deny plaintiff's statement with respect to Pima Foundation. (*See* Responses 44 through 54 of Defendant Maricopa Foundation for Medical Care's Responses to Plaintiff's First Request for Admissions and Interrogatories.)

16. With respect to Plaintiff's Statement 16, at no time has Maricopa Foundation set a maximum reimbursable level of compensation for medical services provided to patients insured under Maricopa Foundation endorsed medical health insurance plans in excess of what Maricopa Foundation's Board of Trustees believed to be the prevailing average or median usual and customary fee charged by doctors in Maricopa County for their services. Maricopa

Foundation has no information sufficient to admit or deny plaintiff's statement with respect to Pima Foundation. (Mitten Aff., Dec. 11, 1978, para. 6.)

17. With respect to Plaintiff's Statement 17, Maricopa Foundation has in the past sent to its members, and to non-member doctors who request membership information and applications, lists of conversion factors used by it to determine maximum reimbursable levels of compensation to doctors providing medical services to patients insured under Maricopa Foundation endorsed health insurance plans. Maricopa Foundation does not publish or distribute relative value schedules or conversion factors used by it to non-members except to insurers who may be interested in underwriting Maricopa Foundation endorsed health insurance plans and persons eligible for membership in Maricopa Foundation who have expressed an interest in joining the Maricopa Foundation. Maricopa Foundation has no information sufficient to admit or deny plaintiff's statement with respect to Pima Foundation, Pima Society, and Maricopa Society. (*See* Responses 57 and 58 of Defendant Maricopa Foundation for Medical Care's Responses to Plaintiff's First Request for Admissions and Interrogatories; Mitten Aff., Dec. 11, 1978, para. 2.)

18. With respect to Plaintiff's Statement 18, Maricopa Foundation has only sent to Pima Foundation conversion factors used by Maricopa Foundation to determine maximum reimbursable levels of compensation to doctors providing medical services to patients insured under Maricopa Foundation endorsed health insurance plans for use for that purpose. Maricopa Foundation has no information sufficient to admit or deny that Pima Foundation subsequently adopted any Maricopa Foundation conversion factors or relative value schedules. (*See*, Response 63 of Defendant Maricopa Foundation for Medical Care's Responses to Plaintiff's First Request for Admissions and Interrogatories.)

20. With respect to Plaintiff's Statement 20, Maricopa Foundation has endorsed certain health insurance plans which are underwritten by private insurers and meet Maricopa Foundation "minimum standards for Foundation-endorsed group insurance plans." Maricopa Foundation has no information sufficient to admit or deny this statement with respect to Pima Foundation. (*See*, Response 11 of Defendant Maricopa Foundation for Medical Care's Responses to Plaintiff's First Request for Admissions and Interrogatories.)

21. With respect to Plaintiff's Statement 21, the minimum standards for Maricopa Foundation endorsed health isurance plans include a list of medical services, goods, and equipment for which the insurer is required to provide reimbursement to insured patients. Maricopa Foundation has no information sufficient to admit or deny this statement with respect to Pima Foundation. (*See, e.g.*, Responses 9 through 12 of Defendant Maricopa Foundation for Medical Care Responses to Plaintiff's First Request for Admissions and Interrogatories.)

22. With respect to Plaintiff's Statement 22, the Maricopa Foundation has entered into agreements with insurers wherein insurers agree to reimburse doctors for services rendered to patients insured under Maricopa Foundation endorsed health insurance plans in accordance with their usual and customary fees charged for such services but not to exceed the maximum reimbursement level of compensation set forth in the Maricopa Foundation's "minimum standards for Foundation-endorsed group insurance programs" except at the insurer's discretion. Maricopa Foundation does not affect in any way prices paid for goods and products sold by doctors to Foundation policyholders and has no price list or schedule for them. Maricopa Foundation has no information sufficient to admit or deny this

statement with respect to Pima Foundation. (*See*, Response 12 of Defendant Maricopa Foundation for Medical Care's Responses to Plaintiff's First Request for Admissions and Interrogatories; Mitten Aff., Dec. 11, 1978, para. 8.)

23. With respect to Plaintiff's Statement 23, maximum reimbursement levels of compensation to doctors providing medical services to patients insured under Maricopa Foundation endorsed health insurance plans have a direct and substantial effect upon insurance reimbursements paid to doctors and health insurance premiums charged for Foundation endorsed health insurance plans.

24. With respect to Plaintiff's Statement 24, it is the practice of Maricopa Foundation to advise insurers underwriting health insurance plans endorsed by Maricopa Foundation in advance of expected changes to maximum reimbursable levels of compensation to doctors providing medical services to patients insured under Maricopa Foundation endorsed health insurance plans. Defendant has no information sufficient to admit or deny this statement with respect to Pima Foundation, Pima Society, or Maricopa Society. (*See*, Response 61 of Maricopa Foundation for Medical Care's Responses to Plaintiff's First Request for Admissions and Interrogatories.

25. With respect to Plaintiff's Statement 25, participating and cooperating members of Maricopa Foundation have agreed to be bound during the period of membership with respect to services provided to patients insured under Maricopa Foundation endorsed plans to accept a determination by the Maricopa Foundation consistent with the schedule adopted by the membership for determining the maximum reimbursable payment as full payment of fees for medical services rendered by them to such patients unless the patient refuses to assign benefits to the member or has multiple health insurance coverage. Maricopa Foundation has no information sufficient to admit or deny this state-

ment with respect to Pima Foundation. (*See*, Response 14 of Maricopa Foundation for Medical Care's Responses to Plaintiff's First Request for Admissions and Interrogatories.)

26. With respect to Plaintiff's Statement 26, Maricopa Foundation repeats its response to statement 25 and further states that pursuant to the minimum standards for Foundation endorsed group insurance programs, assignment of benefits by insureds to doctors who are foundation members is automatic. (*See*, Response 16 of Maricopa Foundation for Medical Care's Responses to Plaintiff's First Request for Admissions and Interrogatories.)

27. With respect to Plaintiff's Statement 27, with respect to some health insurance plans endorsed by Maricopa Foundation, participating and cooperating members of Maricopa Foundation may submit assigned claims for doctors' services provided to patients insured under those plans to Maricopa Foundation. With respect to some health insurance plans endorsed by Maricopa Foundation, Maricopa Foundation writes drafts on the insurer's account as agent of the insurer to pay assigned claims for participating and cooperating members of Maricopa Foundation. Maricopa Foundations has no information sufficient to admit or deny plaintiff's statement with respect to Pima Foundation. (*See*, Responses 65 and 66 of Defendant Maricopa Foundation for Medical Care's Responses to Plaintiff's First Request for Admissions and Interrogatories.)

28. With respect to Plaintiff's Statement 28, members of Maricopa Foundation review claims submitted for services performed on patients insured under Foundation plans to determine if those services were medically necessary or appropriate and if they were adequately described in the claim. Maricopa Foundation does not review prices for goods and products. Maricopa Foundation only reviews doctors' prices for services to the extent of determining whether a fee charged by a doctor is so excessive as to constitute unprofessional conduct pursuant to A.R.S. § 32-1451

which should be brought to the attention of the Arizona Board of Medical Examiners. Maricopa Foundation has no information sufficient to admit or deny plaintiff's statement with respect to Pima Foundation. (*See*, Response 71 of Defendant Maricopa Foundation for Medical Care's Responses to Plaintiff's First Request for Admissions and Interrogatories; Mitten Aff., Dec. 11, 1978, paras. 8, 9.)

29. With respect to Plaintiff's Statement 29, the claim forms approved for use by participating and cooperating members of Maricopa Foundation have spaces for setting forth the usual and customary fee they have billed to the patient. Maricopa Foundation has a preferred claim form but other claim forms may be used. Maricopa Foundation has no information sufficient to admit or deny plaintiff's statement with respect to Pima Foundation, Pima Society, or Maricopa Society. (*See*, Responses 67 and 69 of Defendant Maricopa Foundation for Medical Care's Responses to Plaintiff's First Request for Admissions and Interrogatories.)

30. With respect to Plaintiff's Statement 30, Maricopa Foundation enters membership agreements with its participating and cooperating members annually. A copy of a current application is Exhibit A to the November 17, 1978 Mitten Affidavit. Maricopa Foundation has no information sufficient to admit or deny plaintiff's statement with respect to Pima Foundation. (*See, e.g.*, Response 13 of Defendant Maricopa Foundation for Medical Care's Responses to Plaintiff's First Request for Admissions and Interrogatories.)

31. With respect to Plaintiff's Statement 31, applications for participating and cooperating membership in Maricopa Foundation provide that those members agree to be bound during the period of membership applied for with respect to services provided to patients insured under Maricopa Foundation endorsed health insurance plans, to accept a determination by Maricopa Foundation consistent with the schedule adopted by the membership for determining the

maximum reimbursable payment as full payment of fees for medical services rendered by them to such patients unless the patient refuses to assign benefits to the member or has multiple health insurance coverage. Maricopa Foundation has no information sufficient to admit or deny plaintiff's statement with respect to Pima Foundation. (*See, e.g.*, Response 14 of Defendant Maricopa Foundation for Medical Care's Responses to Plaintiff's First Request for Admissions and Interrogatories.)

32. With respect to Plaintiff's Statement 32, Maricopa Foundation was founded, *inter alia*, to promote the practice of medicine in Maricopa County on a fee for service basis. Maricopa Foundation has no information sufficient to admit or deny plaintiff's statement with respect to Pima Foundation. (*See, e.g.*, Response 91 of Defendant Maricopa Foundation for Medical Care's Responses to Plaintiff's First Request for Admissions and Interrogatories.)

34. Maricopa Foundation has no information sufficient to admit or deny plaintiff's statement 34.

35. Maricopa Foundation has no information sufficient to admit or deny plaintiff's statement 35 with respect to Pima Foundation.

36. With respect to Plaintiff's Statement 36, the only class of member of the Maricopa Foundation with the privilege of voting in the Maricopa Foundation is administrative members, except that participating and cooperating members have the right to vote on the adoption of maximum reimbursable levels of compensation to doctors providing medical services to patients insured under Maricopa Foundation endorsed health insurance plans and that the Board of Trustees of Maricopa Foundation has full and sole power to control and manage the property and conduct the affairs and business of Maricopa Foundation and have general voting power with respect thereto. Maricopa Foundation has no information sufficient to admit or deny plaintiff's state-

ment with respect to Pima Foundation. (*See, e.g.*, Response 4 of Defendant Maricopa Foundation for Medical Care's Responses to Plaintiff's First Request for Admissions and Interrogatories.)

37. With respect to Plaintiff's Statement 37, Maricopa Foundation's participating and cooperating members have the right to vote on the adoption of maximum reimbursable levels of compensation of doctors providing medical services to patients insured under Maricopa Foundation endorsed health insurance plans, including adoption of conversion factors used with relative value schedules for that purpose. Maricopa Foundation has no information sufficient to admit or deny plaintiff's statement with respect to Pima Foundation. (*See*, Response 34 of Defendant Maricopa Foundation for Medical Care's Responses to Plaintiff's First Request for Admissions and Interrogatories.)

38. Maricopa Foundation has no information sufficient to admit or deny plaintiff's statement 38.

39. Maricopa Foundation has no information sufficient to admit or deny Plaintiff's Statement 39.

40. Maricopa Foundation has no information sufficient to admit or deny Plaintiff's Statement 40.

41. Maricopa Foundation denies Plaintiff's Statement 41 with respect to Maricopa Foundation. Maricopa Foundation has no information sufficient to admit or deny the statement with respect to Pima Foundation, Pima Society, or Maricopa Society. (*See, e.g.*, Responses 25 and 26 of Defendant Maricopa Foundation for Medical Care's Responses to Plaintiff's First Request for Admissions and Interrogatories.)

B. Maricopa Foundation incorporates herein by reference the facts set forth in the affidavits of Anthony D. Mitten, sworn to November 17, 1978 and December 11, 1978, which set forth material facts precluding summary judgment in favor of plaintiff. December 11, 1978.

(Signatures omitted in printing.)

(Caption omitted in printing.)

Filed - DEC 12, 1978
W. J. Furstenau, Clerk
U. S. District Court
For The District of Arizona

MARICOPA FOUNDATION FOR MEDICAL CARE'S MEMORANDUM IN OPPOSITION TO PLAINTIFF'S MOTION FOR PARTIAL SUMMARY JUDGMENT ON THE ISSUE OF LIABILITY

Preliminary Statement

Plaintiff's motion for patrial summary judgment on the issue of liability should be denied for three reasons:

1. There are genuine issues as to material facts precluding summary judgment;

2. The acts of Maricopa Foundation for Medical Care ("Maricopa Foundation") are not *per se* violations of the Sherman Act or Arizona's antitrust laws;

3. Plaintiff has not carried its burden of establishing that the acts of Maricopa Foundation violate the Sherman Act or Arizona's antitrust laws under the Rule of Reason.

Argument

A. There are Genuine Issues of Material Facts Which Preclude Granting Plaintiff's Motion for Partial Summary Judgment on the Issue of Liability.

It is characteristic of plaintiff's conduct of this litigation that its motion for partial summary judgment and "Statement of Undisputed Facts" were prepared and filed prior to the time that it received the responses of Maricopa Foundation to Plaintiff's First Request for Admissions and prior to the deposition of the representative of Maricopa Foundation which plaintiff had noticed. As Maricopa Foundation's Statement of Disputed Material Facts, filed pursuant to

Local Rule 11(h), demonstrates, plaintiff would not have taken up the Court's time with this motion if it had waited until it had received the discovery which it requested before filing the motion.

Plaintiff claims "Defendants do not and cannot dispute that they and their members have used and continue to use agreed upon fee schedules to set prices for services, goods and products sold by doctors in Arizona." (Plaintiff's Memorandum, p. 2.) Once again, plaintiff has misunderstood the facts. The affidavit of Anthony D. Mitten sworn to November 17, 1978, and delivered to plaintiff prior to its filing its motion for partial summary judgment on the issue of liability, clearly establishes that Maricopa Foundation does not itself or in combination with anyone else set prices for services, goods and products sold by doctors in Arizona. That affidavit states

> "4. The only determinations with respect to fees charged for medical services which are made by Maricopa Foundation are with respect to maximum fees paid with respect to patients covered by Foundation endorsed plans to participating members in Maricopa Foundation. They agree to accept the Foundation's determination of maximum fees as payment in full for services performed by them on patients covered by Foundation endorsed plans when they bill the patient more than that amount. If the patient is billed less than that amount, the physician is paid the amount billed if the services are determined by Maricopa Foundation to have been medically appropriate. Maricopa Foundation does not and never has taken any position with respect to the amount of fees a participating member or other physician should bill with respect to any medical care for any patient. . . ."

Furthermore, as plaintiff is well aware,

> "Each participating member in Maricopa Foundation executes an application for membership, a true copy of which is attached hereto as Exhibit "A". That application for membership specifically states 'I understand

and agree that participating membership in the Foundation shall not affect the method of computation or amount of fees billed by me with respect to any medical care for any patient.' " *Id.*, para. 3.

The affidavit of Anthony D. Mitten, sworn to December 11, 1978, also makes clear that Maricopa Foundation's Board of Trustees does not believe that the maximum reimbursable level of compensation for medical services provided to patients insured under Maricopa Foundation endorsed medical health insurance plans is in excess of the prevailing average or median usual and customary fee charged by doctors in Maricopa County for their services. (Aff., para. 6.) Furthermore, Maricopa Foundation exercises no control whatsoever over prices for goods and products sold by doctors in Arizona. (Aff., para. 8.) The only action Maricopa Foundation has ever taken with respect to fees charged by doctors is to bring to the attention of the Arizona Board of Medical Examiners pursuant to A.R.S. § 32-1451 those instances in which, in the opinion of the Board of Trustees of Maricopa Foundation, the fee charged by the doctor is so excessive as to constitute unprofessional conduct. (Mitten Aff., para. 9.) Plaintiff's extensive reliance upon a deposition of a representative of Pima Foundation as establishing what Pima Foundation does is irrelevant to any determination as to what Maricopa Foundation does.*

B. The Acts of Maricopa Foundation Are Not a Per Se Violation of the Sherman Act.

Plaintiff's contention that "The Supreme Court has made it unmistakably clear that members of the so-called 'learned professions' are subject to the same antitrust scrutiny as anyone else" (Plaintiff's Memorandum, p. 10) in

* Furthermore, review of the Gerdenics deposition and other evidence in the record will show that the out-of-context quotations from the deposition only relate to a hypothetical instance in which Pima Foundation's relative values and conversion factors were being used to determine a fee charged, not the actual practice in the community.

reliance upon *National Society of Professional Engineers v. United States*, _____ U.S. _____, 98 S. Ct. 1355 (1978) and *Goldfarb v. Virginia State Bar*, 421 U.S. 773 (1975) stands those opinions on their heads.

Neither case applied a *per se* rule to a factual situation which the Court determined to constitute price fixing. In the *Goldfarb* case, the Court went out of its way to state

> "The fact that a restraint operates upon a profession as distinguished from a business is, of course, relevant in determining whether that particular restraint violates the Sherman Act. It would be unrealistic to view the practice of professions and interchangeable with other business activities, and automatically to apply to the professions antitrust concepts which originated in other areas. The public service aspect, and other features of the professions, may require that a particular practice, which could properly be viewed as a violation of the Sherman Act in another context, be treated differently. We intimate no view on any other situation than the one with which we are confronted today."

421 U.S. at 788, n.17.

In *Professional Engineers*, the Court went out of its way to reiterate that "certain practices by members of a learned profession might survive scrutiny under the Rule of Reason even though they would be viewed as a violation of the Sherman Act in another context." 98 S. Ct. at 1362. The Court then quoted in its entirety note 17 from the *Goldfarb* decision in the text of the *Professional Engineers* decision.

In *Professional Engineers*, although, as plaintiff notes, the Supreme Court stated that the activities of defendants constituted an agreement interfering with free market prices which was illegal on its face, nonetheless, the court felt it necessary to undertake an elaborate analysis for the purpose of determining that defendants' conduct was not justified under the Rule of Reason. The court affirmed not because it found a *per se* violation but "Because we are satisfied that the asserted defense rests on a fundamental

misunderstanding of the Rule of Reason frequently applied in antitrust litigation. . . ." 98 S. Ct. at 1360. If plaintiff's contentions were correct, none of the analysis in *Professional Engineers* would have been necessary. The court merely would have stated that defendants' conduct constituted a *per se* violation and affirmed on that ground.

Plaintiff also has ignored the controlling decision of *Boddicker v. Arizona State Dental Association*, 549 F.2d 626 (9th Cir.), *cert. denied*, 434 U.S. 825 (1977).* In *Boddicker*, the Ninth Circuit made clear that pursuant to *Goldfarb*, a *per se* analysis should not be applied to professions.

> ". . . . the Supreme Court does not require that the practices challenged here be treated the same as would be proper if dentistry were merely a commercial enterprise.
>
> As we interpret the Court, to survive a Sherman Act challenge a particular practice, rule, or regulation of a profession, whether rooted in tradition or the pronouncements of its organizations, must serve the purpose for which the profession exists, *viz.* to serve the public. That is, it must contribute directly to improving service to the public. Those which only suppress competition between practitioners will fail to survive the challenge. This interpretation permits a harmonization of the ends that both the professions and the Sherman Act serve.
>
> We recognize this interpretation provides only the principle to be employed in deciding specific cases. It is not a blueprint which will resolve all controversies and by which the professions can check their struc-

* This is particularly strange, since plaintiff relied extensively on the *Boddicker* decision to support its motion for partial summary judgment on the issue of subject matter jurisdiction. (Plaintiff's Memorandum in Support of Motion for Partial Summary Judgment on the Issue of Subject Matter Jurisdiction, p. 8.)

> tures to determine whether they comply with the Sherman Act. Any such blueprint must await additional guidance by the Supreme Court and resolution of specific cases by this and other courts."

549 F.2d at 632.

Plaintiff's attempt to apply a mechanical, unthinking, and rigid *per se* analysis to defendants in this action, as if they were selling gasoline instead of engaged in the medical profession, is not well-founded.* Applying the Ninth Circuit's standard from the *Boddicker* case, Maricopa Foundation's activities clearly must be subject to a Rule of Reason analysis, weighing any alleged suppression of competition against the contribution to the public. Since Maricopa Foundation is undisputedly a vehicle by which the medical profession offers a low cost health care alternative to people of the community, the Rule of Reason must be applied.

C. The Acts of Maricopa Foundation Are Not a Per Se Violation of Arizona's Antitrust Laws.

Maricopa Foundation agrees with plaintiff that the standards enunciated by the Supreme Court in applying the Sherman Act should also be used in applying Arizona's antitrust laws. A.R.S. § 44-1412. Since the Supreme Court would apply the Rule of Reason as the standard for judging the activities of Maricopa Foundation under the Sherman Act, it should also be applied as the standard for judging the activities of Maricopa Foundation under Arizona's antitrust laws.

D. Plaintiff Has Not Carried Its Burden of Establishing That the Acts of Maricopa Foundaiton Violate the Rule of Reason.

Plaintiff relies exclusively on *Professional Engineers* to support its contention that the activities of Maricopa Foun-

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* The Fifth Circuit has also rejected mechanical application of *per se* rules developed for business activities. See *Hennessey v. National Collegiate Athletic Ass'n*, 564 F.2d 1136 (5th Cir. 1977).

dation violate the Rule of Reason. *Professional Engineers* was an action by the United States against the National Society of Professional Engineers in which it alleged the Society's canon of ethics which prohibited its members from submitting competitive bids for engineering services violated Section 1 of the Sherman Act.

The Supreme Court formulated the legal standard to be applied under the Rule of Reason as follows:

> [T]he inquiry mandated by the Rule of Reason is whether the challenged agreement is one that promotes competition or one that suppresses competition.

98 S. Ct. at 1365. Applying this standard to the facts before it, the Court found the canon amounted to an agreement among competitors to refuse to discuss prices with potential customers prior to the selection of an engineer—a clear suppression of competition.

Unlike the canon of ethics in *Professional Engineers*, the activities of Maricopa Foundation promote, rather than suppress, competition. First, plaintiff's contention that Maricopa Foundation fixes prices is not supported by the facts. There is no undisputed factual basis to find competition is suppressed. Second, Maricopa Foundation was established to provide residents of Maricopa County with a competitive alternative to closed panel prepaid health insurance plans (HMO's). (Mitten Aff., Nov. 17, 1978, para. 2) At present, Maricopa Foundation endorsed insurance plans compete in the open market with the other types of health insurance plans available in Arizona. The Foundation's maximum reimbursement levels, which are attacked by plaintiff, are essential to the concept and operation of the Foundation insurance plans. These maximum reimbursement levels have helped Maricopa Foundation control the rising cost of health care for policyholders of Foundation endorsed health insurance plans. The Foundation establishes maximum levels of reimbursement believed not to exceed usual and customary fees in Maricopa County. (Mitten Aff., Dec. 11, 1978, para. 6.) By providing the alter-

native of Foundation endorsed insurance plans to consumers, the Maricopa Foundation promotes competition. Therefore, its activities are squarely within the Rule of Reason as enunciated by the Supreme Court in *Professional Engineers* and the Ninth Circuit in *Boddicker*.

Conclusion

Plaintiff's motion for partial summary judgment on the issue of liability should be denied. There are genuine issues as to numerous material facts. In the event that this Court finds that there is no genuine issue as to controlling material facts, Maricopa Foundation's activities should be judged under the Rule of Reason and found not to constitute antitrust violations because they promote, rather than suppress, competition and serve the public.

December 11, 1978.

(Signature omitted in printing.)

Filed DEC 21, 1978
W. J. Furstenau, Clerk
U. S. District Court
For The District of Arizona

(Caption omitted in printing.)

STATEMENT OF UNDISPUTED FACTS SUPPORTING PLAINTIFF'S MOTION FOR PARTIAL SUMMARY JUDGMENT ON THE ISSUE OF LIABILITY WITH SUPPLEMENTAL REFERENCES

Pursuant to Rule 11(h), Rules of Practice of the United States District Court for the District of Arizona 1978, plaintiff filed and served on November 20, 1978 a Statement of Undisputed Facts Supporting Plaintiff's Motion for Partial Summary Judgment on the Issue of Liability. That Statement was based upon and contained references to the documents and testimony available to plaintiff as of November 20, 1978. Since that date plaintiff has taken the deposition of defendant Maricopa Foundation for Medical Care by its designee Anthony D. Mitten on November 22, 1978 (hereinafter Mitten Deposition), and has received defendants' responses to Plaintiff's First Request for Admissions (Exhibits A, B, and C), defendants' stipulations with respect to the authenticity of certain documents, (Exhibit D) and additional business records of defendants (*e.g.*, Exhibits E through M.) For the convenience of the Court and parties, plaintiff hereby submits the identical Statement of Undisputed Facts which it filed on November 20, 1978 with supplemental references to the testimony, admissions and documents which plaintiff has discovered since that date.

1. Each of the defendants is an association of doctors. (*See, e.g.*, Exhibit MF-122 to Plaintiff's First Request for Admissions; Deposition of Defendant Pima Foundation for Medical Care by its designee Mary Gerdenics, taken November 14, 1978 (hereinafter "Gerdenics Deposition"), Exhibit 45, Defendants' Answers to Interrogatory No. 1; Defendant Maricopa County Medical Society's Responses

to Plaintiff's First Request for Admissions and Interrogatories, attached hereto as Exhibit C (hereinafter "Maricopa Society's Admissions") No. 309; Plaintiff's First Request for Admissions and Interrogatories and Responses of Defendant Maricopa Foundation for Medical Care, attached hereto as Exhibit 3 (hereinafter "Maricopa Foundation's Admissions") Nos. 310, 311; Response of Defendant Pima Foundation for Medical Care to Plaintiff's First Request for Admissions and Interrogatories (attached hereto as Exhibit A) (hereinafter "Pima Foundations's Admissions") No. 428.)

2. Over 1000 doctors in Maricopa County have agreed to abide by the fee schedules adopted by the membership of defendant Maricopa Foundation for Medical Care (hereinafter "Maricopa Foundation"). (*See, e.g.*, Exhibits MF-51 and MF-112 through MF-118 to Plaintiff's First Request for Admissions; Mitten Deposition, Exhibit 55; Maricopa Foundation's Admissions No. 268; Exhibit MF-64 to Plaintiff's First Request for Admissions, § I, ¶10.)

3. Over 400 doctors in Pima County have agreed to abide by the fee schedules adopted by the membership of defendant Pima Foundation for Medical Care (hereinafter "Pima Foundation"). (*See, e.g.*, Gerdenics Deposition, pp. 27-28, Exhibits 6, 45, 46, 48 § I, ¶8; Exhibit PF-125 to Plaintiff's First Request for Admissions; Opposition to Plaintiff's Motion for Partial Summary Judgment on the Issue of Subject Matter Jurisdiction filed by Defendant Pima Foundation (hereinafter "Pima Foundation's Opposition"), p. 14; Affidavit of Thomas P. Finley attached to Pima Foundation's Opposition (hereinafter "Finley Affidavit") ¶7.)

4. To determine the price allowed for a doctor's service under the foundation fee schedules, one must refer to both a relative value schedule and a unit conversion factor. (*See, e.g.*, Gerdenics Deposition, pp. 24-26, Exhibit 48, § IV ¶3(A); Exhibits MF-70, MF-102, PF-109, and MF-64, § IV, ¶3(A), to Plaintiff's First Request for Admissions; Maricopa Foundation's Admissions No. 17; Mitten Deposition, Vol. I

pp. 90-92, 99-100; Pima Foundation's Admissions No. 17; Finley Affidavit ¶17; Pima Foundation's Opposition, at p. 8 ("In the present case, the uniform fee schedule is drawn in part from a physician's Relative Value Schedule.")

5. A relative value schedule is a compilation of medical services which assigns a comparative unit value to each service listed. (*See, e.g.*, Gerdenics Deposition, pp. 25, 41-49, Exhibit 18; Mitten Deposition, Vol. I pp. 70-96; Exhibits E, F, G, and H.)

6. A unit conversion factor is a dollar or number value used to multiply the unit value of a service into a dollar amount payable for that service. (*See, e.g.*, Gerdenics Deposition, pp. 28, 44; Exhibit MF-102 to Plaintiff's First Request for Admissions; Mitten Deposition, Vol. I pp. 96-100, Exhibit 28. *See* Maricopa Foundation's Admissions No. 160.)

7. Defendants and their members have used relative value schedules prepared by the California Medical Association, the American Society of Anesthesiologists and the American College of Radiology. (Defendants' Answers to Interrogatory No. 13, Gerdenics Deposition, pp. 41-49, 82-86, Exhibit 18; Mitten Deposition, Vol. I pp. 71-82, Vol. II pp. 97-100; Maricopa Foundation's Admissions Nos. 19, 21, 23, 160; Pima Foundation's Admissions Nos. 19, 21, 23, 38, 323; *see* Exhibits E, F, G, and H.)

8. The Maricopa Foundation prepared a relative value schedule for use by Arizona doctors. (Maricopa Foundation's Answer to Interrogatory No. 13; Exhibits MF-24, MF-49, MF-70, MF-71, MF-76 and MF-120 to Plaintiff's First Request for Admissions; Maricopa Foundation's Admissions Nos. 18, 29, 196. *See* Mitten Deposition, Vol. I pp. 71-76, 83-84, Exhibits 38, 66; Exhibits E and M.) (The Pima Foundation has also prepared relative value schedules. *See* Pima Foundation's Admissions No. 18.)

9. In concert with their members and various groups of doctors in Arizona, defendants have:

(a) publicized and encouraged the use of certain relative value schedules;

(b) updated and revised the relative value schedules used by their members;

(c) increased the relative values accorded to some doctors' services on the relative value schedules used by their members.

(*See, e.g.*, Gerdenics Deposition, pp. 84-86, Exhibit 48, § V; Exhibits PS-1, PF-1, PF-127 through PF-129, MF-47, MF-64, § V, MF-99, MF-100, MF-107 and MF-107A to Plaintiff's First Request for Admissions; Maricopa Society's Admissions No. 197; Maricopa Foundation's Admissions Nos. 28, 32, 122, 136, 137, 139, 193, 248, 261, 262, 263, 283, 296; Mitten Deposition, Vol. I pp. 73-84, 95-96, Vol. II pp. 97-100, Exhibits 56, 65, 66; Pima Foundation's Admissions Nos. 28, 32, 318, 319, 321, 322, 323, 326, 328, 329, 330, 331, 332, 333, 334, 335, 336, 399, 410, 414, 424.)

10. Foundation fee schedules provide unit conversion factors for six categories of relative values (*See* Exhibits PF-1, PF-146, MF-63 and MF-121 to Plaintiff's First Request for Admissions; Gerdenics Deposition, Exhibits 20, 25, 26, 27, 28, 29; Mitten Deposition, Vol. I pp. 96-104, Exhibit 28 (attached hereto as Exhibit I); Maricopa Foundation's Admissions Nos. 93, 94, 95, 96, 229, 233, 304; Pima Foundation's Admissions Nos. 344, 349, 364, 413, 426.)

11. Foundation fee schedules have been adopted periodically by majority vote of foundation members conducted by mail ballot. (*See, e.g.*, Gerdenics Deposition, pp. 63-74, Exhibits 24, 25; Exhibits PF-3, PF-107, PF-111, PF-114, PF-132, PF-135, PF-151, PF-154, MF-1, MF-70, MF-88, MF-93, MF-95 and MF-102 to Plaintiff's First Request for Admissions; Mitten Deposition, Vol. I pp. 114-118, Vol. II pp. 10-11, Exhibits 28, 31, 34 (attached hereto as Exhibits I,

J, and K); Finley Affidavit ¶18; Maricopa Foundation's Admissions Nos. 34, 36, 156, 157, 158, 164, 234, 235; Pima Foundation's Admissions Nos. 34, 347, 348, 362, 363, 402, 403, 409, 412, 423, 425.)

12. The Maricopa Foundation has periodically polled its members with respect to:

(a) the fees they usually charge for their services;

(b) the relative value schedules and unit conversion factors they use or prefer;

(c) the relative value schedules and unit conversion factors they consider appropriate for foundation fee schedules.

(*See, e.g.*, Exhibits MF-1, MF-2, MF-3, MF-59, MF-72 and MF-97 to Plaintiff's First Request for Admissions; Maricopa Foundation's Admissions Nos. 37, 41, 54, 119, 153, 154, 225, 226, 257, 297, 298, 299, 301; Mitten Deposition, Vol. II pp. 90-92, Exhibits 59, 63.)

13. The Maricopa Foundation has periodically polled various doctors' associations with respect to:

(a) the fees their members usually charge for their services;

(b) the relative value schedules and unit conversion factors their members use or prefer;

(c) the relative value schedules and unit conversion factors which their members consider appropriate for foundation fee schedules.

(*See, e.g.*, Exhibits MF-6 through MF-19 and MF-27 through MF-46 to Plaintiff's First Request for Admissions; Maricopa Foundation's Admissions Nos. 44, 54, 123, 124, 130, 160, 256, 261, 269, 279, 281, 282, 284, 285, 286, 287, 290, 291, 292, 293, 295, 300; Mitten Deposition, Vol. II pp. 87-88, Exhibits 59, 61.)

14. Defendant foundations have consulted with various doctors' associations with respect to:

(a) the relative value schedules and unit conversion factors which their members use or prefer;

(b) the relative value schedules and unit conversion factors which their members consider appropriate for foundation fee schedules;

(c) the relative values to be accorded certain procedures;

(d) the services, goods and products sold by doctors for which coverage should be required under foundation plans.

(*See, e.g.*, Exhibits PF-109, PF-113, PF-169 through PF-182, PF-184 through PF-194, MF-57, MF-58, MF-60, MF-65 through MF-67, MF-77, MF-79, MF-81, MF-99, MF-100, MF-103 and MF-104 to Plaintiff's First Request for Admissions; Maricopa Foundation's Admissions Nos. 44, 54, 104, 105, 106, 107, 112, 113, 114, 122, 126, 134, 135, 137, 166, 167, 179, 183, 193, 237, 238, 251, 252, 253, 258, 260, 261, 262, 263, 283, 284, 285, 287, 290, 291, 292, 293, 295, 296; Mitten Deposition, Vol. I p. 96, Exhibits 11, 59, Pima Foundation's Admissions Nos. 44, 54, 319, 320, 321, 322, 323, 326, 328, 329, 330, 331, 332, 333, 334, 335, 336, 360, 414.)

15. Defendant foundations have consulted with their members and various doctors' associations in connection with the preparation of foundation fee schedules. (*See, e.g.* Exhibits MF-3, MF-4, and MF-62 to Plaintiff's First Request for Admissions; Maricopa Foundation's Admissions Nos. 44, 54, 250; Mitten Deposition, Exhibits 59, 61, 66; Pima Foundation's Admissions Nos. 44, 54, 319-338.)

16. Foundation conversion factors have been set higher than average and median doctors' prices shown by price surveys. (*See, e.g.*, Exhibits MF-51, MF-71 to Plaintiff's First Request for Admissions; *see* Maricopa Foundation's Admissions Nos. 227 throught 234 and 269 through 276; Mitten Deposition, Vol. II pp. 92-94, Exhibit 63.)

17. Defendants have published and distributed foundation fee schedules to members and non-members alike. For example, foundation fee schedules have been published in the regular publications of the defendant societies. (*See, e.g.*, Exhibits PS-1 and MS-14 to Plaintiff's First Request for Admissions; Maricopa Society's Admissions Nos. 60, 101, 102, 103, 117, 172, 173, 197; Maricopa Foundation's Admissions Nos. 57, 58, 169, 176; Pima Foundation's Admissions Nos. 57, 58, 346, 350, 356, 365, 366, 368, 375, 402, 409; Affidavit of Anthony D. Mitten dated December 11, 1978, ¶2.)

18. The Maricopa Foundation has sent the Pima Foundation copies of fee schedules adopted by the Maricopa Foundation, and the Pima Foundation has subsequently adopted those fee schedules. (*See, e.g.*, Gerdenics Deposition, p. 60; Exhibits PF-132, PF-135, PF-148, PF-151 and PF-154 to Plaintiff's First Request for Admissions; Maricopa Foundation's Admissions Nos. 63, 170, 171, 186; Mitten Deposition, Vol. II pp. 47-48, Exhibit 53; Pima Foundation's Admissions Nos. 63, 358, 359, 361, 362.)

19. Doctors' prices have a direct and substantial effect on payments made and premiums charged for health insurance. (*See, e.g.*, Affidavit of William R. DeWaal, attached as Exhibit 3 to the Statement of Undisputed Facts Supporting Plaintiff's Motion for Partial Summary Judgment on the Issue of Subject Matter Jurisdiction (hereinafter "DeWaal Affidavit"), Exhibits B-2 through B-7, B-9, B-16 and B-17; Maricopa Foundation's Admissions Nos. 143, 224, Mitten Deposition, Vol. I pp. 60-64, Vol. II pp. 6-10, Exhibits 20, 21, 32, 33; Finley Affidavit ¶21.)

20. Defendant foundations have endorsed certain health insurance plans (hereinafter referred to as Foundation Plans) which are underwritten by private insurers and meet certain "minimum standards" formulated by defendents. (*See e.g.*, Affidavit of Roger Beck, attached as Exhibit A to Statement of Undisputed Facts Supporting Plaintiff's Motion for Partial Summary Judgment on the Issue of Subject

Matter Jurisdiction (hereinafter "Beck Affidavit"), Exhibits A-3, A-4, A-5, and A-9; DeWaal Affidavit, Exhibits B-6, B-14, B-15, B-17, B-26 and B-27; Gerdenics Deposition, pp. 27-28, Exhibit 48; Mitten Deposition, Vol. I pp. 19-23; Exhibit MF-64 to Plaintiff's First Request for Admissions; Maricopa Foundation's Admissions Nos. 6, 7; Pima Foundation's Admissions Nos. 6, 7.)

21. Defendants' minimum standards for foundation plans include, among other things, coverage of a wide range of services, goods and equipment sold by doctors. (*See e.g.*, Gerdenics Deposition, pp. 110-112, 117, Exhibit 48, §§ II through IV; Exhibit MF-64 to Plaintiff's First Request for Admissions, §§ II through IV; Beck Affidavit, Exhibit A-5, DeWaal Affidavit, Exhibits B-24, B-25, B-26 and B-27; Maricopa Foundation's Admissions No. 9; Pima Foundation's Admissions No. 9).

22. Defendant foundations have made agreements with certain insurers that require the insurers to pay for services, goods and products sold by doctors to foundation policyholders at the prices set by the foundation fee schedules. (*See, e.g.*, Gerdenics Deposition, pp. 22-24, 110-112, Exhibits 5, 6; Beck Affidavit, Exhibits A-2, A-3, A-4 and A-9; DeWaal Affidavit, Exhibits B-1, B-2, B-14, B-15, B-18, B-19 and B-29; Mitten Deposition, Vol. I pp. 21-23, Exhibit 13; Maricopa Foundation's Admissions Nos. 10, 11, 12; Pima Foundation's Admissions Nos. 10, 11, 12.)

23. The prices set by the foundation fee schedules have a direct and substantial effect on payments made and premiums charged for foundation plans. (*See, e.g.*, DeWaal Affidavit, Exhibits B-2 through B-7, B-9 and B-17; Mitten Deposition, Vol. I pp. 60-64, Vol. II pp. 6-10, Exhibits 20, 21, 32, 33; Maricopa Society's Admissions Nos. 146, 147, 188; Maricopa Foundation's Admissions Nos. 143, 188, 224; *See* Finley Affidavit ¶21.)

24. Defendants have provided advance notice of expected increases in foundation fee schedules to insurers that underwrite foundation plans. (*See, e.g.*, Exhibits MF-92, MF-96 and MF-98 to Plaintiff's First Request for Admissions; DeWaal Affidavit, Exhibit B-9; Maricopa Foundation's Admissions Nos. 61, 155, 163, 220, 223, 236; Mitten Deposition, Vol. I pp. 22-25, 51-62, Exhibits 14-18, 22, 59; Pima Foundation's Admissions No. 61.)

25. Foundations members agree to accept the payment allowed by the foundation fee schedule as full compensation on claims assigned to them by foundation policyholders. (*See, e.g.*, Exhibits PF-123, MF-112 through MF-118, MF-64, § I, ¶10, to Plaintiff's First Request for Admissions; Maricopa Foundation's Admissions No. 14; Mitten Deposition, Vol. I p. 110; Affidavit of Anthony D. Mitten dated November 17, 1978, ¶4; Pima Foundation's Admissions No. 14; Gerdenics Deposition Exhibit 48, § I, ¶3; Finley Affidavit ¶16; Pima Foundation's Opposition, at p. 3 ((The Pima Foundation) sets maximum rates for various categories of covered health services.))

26. Unless a foundation policyholder has assigned his or her benefits under a foundation plan in advance, foundation members are not obligated to accept the payments allowed by the foundation fee schedule as full payment for services to that foundation policyholder. (*See, e.g.*, Exhibits MF-64, § I, ¶10, and PF-126 to Plaintiff's First Request for Admissions; Gerdenics Deposition Exhibit 48, § I, ¶8; Maricopa Foundation's Admissions Nos. 14, 16; Pima Foundation's Admissions Nos. 14, 16.)

27. Foundation members have submitted assigned claims for services, goods or products sold to foundation policyholders directly to the foundations and have received payment on those claims directly from the foundations. (*See, e.g.*, Gerdenics Deposition, pp. 112-113, Exhibit 48, § I, ¶4; Exhibit MF-64 § I, ¶6, to Plaintiff's First Request for

Admissions; DeWaal Affidavit, Exhibit B-28, pp. 16-19; Maricopa Foundation's Admissions Nos. 64, 65, 66; Mitten Deposition, Vol. I p. 45; Finley Affidavit ¶9(b); Pima Foundation's Admissions Nos. 64, 65, 66.)

28. Doctors' prices for services, goods and products sold to foundation policyholders have been reviewed by foundation members. (*See, e.g.*, Gerdenics Deposition, pp. 115-116, Exhibits 48, 49; DeWaal Affidavit, Exhibit B-28, pp. 16-19; Maricopa Foundation's Admissions Nos. 70, 71; Finley Affidavit ¶9(b)).

29. The uniform claim form used by defendants has called for the doctor's usual fee for services, goods or products sold to foundation policyholders even if that fee exceeded the price set by the foundation fee schedule. (*See, e.g.*, Gerdenics Deposition, p. 113; Exhibit PF-125 to Plaintiff's First Request for Admissions; Maricopa Foundation's Admissions No. 69; Mitten Deposition, Vol. II pp. 85-86; Pima Foundation's Admissions No. 69.)

30. The foundations' participating and cooperating members have periodically executed applications for foundation membership. (*See, e.g.*, Gerdenics Deposition, pp. 27-28, Exhibit 46; Exhibits PF-123 and MF-112 through MF-118 to Plaintiff's First Request for Admissions; Mitten Deposition, Vol. II pp. 49-50, Exhibit 55; Maricopa Foundation's Admissions No. 13.)

31. Applications for participating and cooperating membership in the foundations have contained an agreement that the foundation member will be bound by the foundation fee schedule. (*See, e.g.*, Gerdenics Deposition, pp. 27-28, Exhibit 46, ¶2; Exhibits PF-123 and MF-112 through MF-118 to Plaintiff's First Request for Admissions; Mitten Deposition Exhibit 55, ¶5; Maricopa Foundation's Admissions No. 14; Pima Foundation's Admissions No. 14.)

32. The defendant societies founded the defendant foundations to promote the interests of fee-for-service medicine. (*See, e.g.*, Exhibits MF-27, MF-70, MF-89, MF-90 and MF-95 to Plaintiff's First Request for Admissions; Maricopa Foundation's Admissions No. 91; Pima Foundation's Admissions No. 317.)

33. The members of the board of directors of the Maricopa County Medical Society (hereinafter "Maricopa Society") have automatically become the administrative members of the Maricopa Foundation. (*See, e.g.*, Exhibit MF-122 to Plaintiff's First Request for Admissions, Ch. II, § 2; Mitten Deposition, Exhibit 30, Ch. II, § 2; Maricopa Society's Admissions No. 3; Maricopa Foundation's Admissions No. 3.)

34. The members of the board of directors of the Pima County Medical Society (hereinafter "Pima Society") have automatically become the administrative members of the Pima Foundation. (*See, e.g.*, Gerdenics Deposition, Exhibit 47, Ch. II, § 2.)

35. As administrative members of the foundations, the members of the boards of directors of the defendant societies have elected or appointed the members of the boards of trustees of the defendant foundations. (*See, e.g.*, Exhibits PS-3 through PS-7, MS-2, MS-10 through MS 13 and MF-67 to Plaintiff's First Request for Admissions; Mitten Deposition, Vol. II pp. 11-12, 14, Exhibit 36; Maricopa Society's Admissions Nos. 5, 177, 245, 264, 267, 308; Maricopa Foundation's Admissions Nos. 177, 245, 264, 267, 308; Pima Foundation's Admissions No. 416.)

36. Administrative members have been the only class of members in each defendant foundation having a general voting power. (*See* Exhibit MF-122 to Plaintiff's First Request for Admissions, Ch. II, § 3; Mitten Deposition, Exhibit 30, Ch. II, § 3; Gerdenics Deposition, Exhibit 47, Ch. II, § 3; Maricopa Foundation's Admissions No. 4.)

37. The By-laws of defendant foundations have given participating and cooperating members the right to vote on the adoption of uniform, average or median fee schedules. (*See e.g.*, Gerdenics Deposition, Exhibit 47 (Ch. II, §§ 5, 7; Exhibit MF-122 to Plaintiff's First Request for Admissions, Ch. II, §§ 5, 7; Mitten Deposition, Exhibit 30, Ch. II, §§ 5, 7; Maricopa Foundation's Admissions No. 34. *See also* the By-laws of the Pima Foundation as amended in October, 1978 [attached hereto as Exhibit N], which provide that "Corporate members shall have the right to vote on the adoption of any contract limits for medical services by the Foundation. Adoption of any such schedule for medical services shall be by mail ballot." Exhibit N, Ch. II, § 2; Pima Foundation's Admissions No. 34.)

38. Defendant societies have known and approved of the activities of defendant foundations. (*See, e.g.*, Exhibits PF-134, PF-139, MS-4, MS-5, MS-7, MF-52, MF-80 and MF-119 to Plaintiff's First Request for Admissions; Gerdenics Deposition, Exhibits 50, 51; Mitten Deposition, Vol. I pp. 4-9; Maricopa Society's Admissions Nos. 198, 200, 201, 203, 222, 314; Maricopa Foundation's Admissions Nos. 198, 199, 200, 201, 202, 203, 222.)

39. Over 70 percent of the doctors in Maricopa County have been members of the Maricopa Foundation. (*See, e.g.*, Exhibit MS-1 to Plaintiff's First Request for Admissions.)

40. Over 70 percent of the doctors in Pima County have been members of the Pima Foundation. (*See, e.g.*, Exhibit PF-125 to Plaintiff's First Request for Admissions.)

41. Defendants have received repeated warnings that their use of agreed-upon relative value schedules and conversion factors violates the antitrust laws. (*E.g.*, Exhibits MF-20 through MF-23 to Plaintiff's First Request for Admissions; Maricopa Society's Admissions No. 242.)

DATED this 21st day of December, 1978.

(Signatures omitted in printing.)

EXHIBIT A

(Caption omitted in printing.)

RESPONSE OF DEFENDANT PIMA FOUNDATION FOR MEDICAL CARE TO PLAINTIFF'S FIRST REQUEST FOR ADMISSIONS AND INTERROGATORIES

* * * *

6. Foundation Plans are underwritten by private insurers which are located in the State of Arizona and elsewhere.

The Pima Foundation admits that only some Pima Foundation-endorsed plans are underwritten by private insurers, each such private insurer doing business from a location in Arizona and at least some do business from locations outside Arizona, and states that otherwise it has no information.

7. To obtain your endorsement as a Foundation Plan, a health insurance plan must comply with the minimum standards formulated by the Foundation.

It admits only that it will not endorse a health insurance plan unless it meets certain minimum standards for Foundation-endorsed group insurance programs.

8. Minimum standards for Foundation Plans are approved by the Board of Trustees of the Foundation.

It admits only that minimum standards for Foundation-endorsed health insurance plans are determined and approved by the Board of Trustees and states that it otherwise has no information.

9. Minimum standards for Foundation Plans inculde, among other things, the doctors' services to be covered under Foundation Plans.

It admits only that minimum standards for Foundation-endorsed health insurance plans include a list of medical services for which the insurer is required to provide reimbursement to insured patients, and states that it otherwise has no information.

10. Minimum standards for Foundation Plans include, among other things, the allowable rate of payment for covered services, goods and products sold by doctors to Foundation policyholders.

It admits only that its "minimum standards for Foundation-endorsed programs" includes a maximum reimbursable payment schedule with respect to payments by the insurer to doctors for services provided to patients insured under Foundation-endorsed health insurance plans, and states that it otherwise has no information.

11. The Foundation has entered into agreements with insurers in which the insurer agreed to comply with the Foundation's minimum standards.

It admits only that it has entered into agreements with insurers pursuant to which those insurers agree to write health insurance for certain groups which is not inconsistent with the Foundation's minimum standards referred to above, and states that it has otherwise no information.

12. The Foundation has entered into agreements with insurers that insurers will pay for services, goods and products sold by doctors to Foundation policy holders at prices up to the amount set in the Foundation fee schedule.

It admits only that it has entered into agreements with insurers wherein insurers agree to reimburse doctors for services rendered to patients insured under Foundation-endorsed health insurance plans in accordance with their usual and customary fees charged for such services, but not

to exceed the maximum reimbursable level of compensation set forth in the Foundation's minimum standards referred to above, except at the insurer's discretion, and states that it otherwise has no information.

13. The Foundation's participating and cooperating members execute applications for membership in the Foundation each year.

Denied.

14. Applications for participating and cooperating membership have contained a provision that the Foundation member will be bound by the fee schedules adopted by Foundation members.

It admits only that its membership agreements with its membership have provided that the members agree to be bound during the period of membership with respect to services provided to patients insured under Foundation-endorsed plans to accept a determination by the Foundation consistent with the schedule adopted by the membership for determining the maximum reimbursable payment as full payment of fees for medical services rendered by them to such patients unless the patients refuse to assign benefits to the member or has multiple health insurance coverage, and states that it has otherwise no information.

15. Foundation members agree to accept the payment allowed by the Foundation fee schedule as full compensation on assigned claims for the covered services, goods and products which they sell to Foundation policyholders.

It repeats its response to Statement 14.

16. Unless a Foundation policyholder has assigned his or her benefits under a Foundation Plan in advance, Foundation members are not obligated to accept the payments allowed by the Foundation fee schedule as full payment for services to that Foundation policyholder.

It repeats its response to Statement 14, and further states that pursuant to the minimum standards for Foundation-endorsed group insurance programs, assignment of benefits by insureds to doctors who are Foundation members is automatic.

17. To determine the fee allowed for a doctor's service under a Foundation Plan, one must refer to both a relative value schedule and a unit conversion factor.

It admits only that to determine the maximum reimbursable payment to a doctor for services provided to a patient insured under a Foundation-endorsed health insurance plan, one must refer both to a relative value schedule and a conversion factor, and states that it has otherwise no information.

18. The Foundation selectes the relative value schedule(s) used to determine the fees allowed for doctors' services under Foundation Plans.

It admits only that the Foundation has prepared Relative Value Schedules used to determine the maximum reimbursable levels of compensation payable by the insurer to doctors for services provided to patients insured under Foundation-endorsed health insurance plans, and states that it otherwise has no information.

19. The Foundation has used a relative value schedule prepared by the California Medical Association.

It admits only that Relative Value Schedules prepared and used by the Foundation are based in part upon the 1964 edition of the Relative Value Schedule adopted by the California Medical Association, and states that it has otherwise no information.

20. The California Medical Association no longer revises or publishes a relative value schedule.

No information.

21. The Foundation has used a relative value schedule prepared by the American Society of Anesthesiologists.

It admits only that Relative Value Schedules prepared and used by the Foundation are based in part upon relative value schedules adopted by the American Society Anesthesiologists and states that it has otherwise no information.

22. The American Society of Anesthesiologists no longer revises or publishes a relative value schedule.

No information.

23. The Foundation has used a relative value schedule prepared by the American College of Radiology.

It admits only Relative Value Schedules prepared and used by the Foundation are based in part upon Relative Value Schedules adopted by the American College of Radiology, and states that it has otherwise no information.

24. The American College of Radiology no longer revises or publishes a relative value schedule.

No information.

25. The Foundation has been informed that agencies of the Federal Government which enforce the federal antitrust laws consider the preparation and publication of a relative value schedule to be a violation of the federal antitrust laws.

Denied.

26. The Foundation has been informed that agencies of the Federal Government which enforce the federal antitrust laws consider the use by doctors of a relative value schedule to be a violation of the federal antitrust laws.

Denied.

27. The Foundation has been informed of legal action taken by agencies of the Federal Government against associations of doctors which have revised and published a relative value schedule.

It states that it does not know what is intended to be referred to by this Request for Admission and objects to it as vague and ambiguous.

28. The Foundation has revised relative value schedules.

It admits only that it has revised its Relative Value Schedules, and states that it has otherwise no information.

29. The Maricopa Foundation prepared a relative value schedule for use in Arizona.

It admits that it has prepared Relative Value Schedules for use in Arizona to determine the maximum reimbursable levels of compensation payable by the insurer to doctors for services provided to patients insured under Foundation-endorsed health insurance plans.

30. The Maricopa Foundation prepared a document entitled "Arizona Medical Services Terminology and Descriptive Index."

No knowledge.

31. The Foundation uses the Arizona Medical Services Terminology and Descriptive Index.

Denied.

32. The Foundation has increased unit values used to determine the fees allowed for some doctors' services under Foundation Plans.

It admits that it has in some instances increased and in some instances decreased the unit value used to determine the maximum reimbursable level of compensation payable by the insurer to doctors for services provided to a patient insured under a Foundation-endorsed health insurance plan, and states that it otherwise has no information.

33. The Foundation fee schedule sets the unit conversion factors used to determine the fees allowed for doctors' services under Foundation Plans.

Denied.

34. Foundation members have the power to vote on the unit conversion factors used to determine the fees allowed for doctors' services under Foundation Plans.

It admits that its members have the right to vote on the adoption of maximum reimbursable levels of compensation to doctors providing medical services to patients insured under Foundation-endorsed health insurance plans, including adoption of conversion factors used with Relative Value Schedules for that purpose, and states that it has otherwise no information.

35. Foundation fee schedules are adopted periodically by majority vote of Foundation members.

Denied.

36. Voting on Foundation fee schedules has been conducted by mail ballot.

Denied.

37. The Foundation has polled its members with respect to the fees they usually charge for their services.

Denied.

38. The Foundation has polled its members with respect to the unit conversion factor(s) they use to determine the fees for their services.

Denied.

39. The Foundation has polled its members with respect to the fees to be allowed for doctors' services under Foundation Plans.

Denied.

40. The Foundation has polled its members with respect to the unit conversion factors to be used to determine the fees allowed for doctors' services under Foundation Plans.

Denied.

41. The Foundation has polled its members with respect to the relative value schedule(s) they use.

Denied.

42. The Foundation has polled its members with respect to the relative value schedule(s) they prefer.

Denied.

43. The Foundation has polled its members with respect to the relative value schedule(s) to be used by the Foundation.

Denied.

44. The Foundation has consulted with various groups of doctors with respect to the fees their members usually charge for their services.

It admits that it has requested various professional organizations whose members are doctors to advise it in connection with its determination of maximum reimbursable levels of compensation to doctors providing medical services to patients insured under Foundation-endorsed health insurance plans to be proposed to the Foundation's members for adoption.

45. The Foundation has consulted with various groups of doctors with respect to the unit conversion factor(s) their members use to determine the fees for their services.

It repeats its response to Statement 44.

46. The Foundation has consulted with various groups of doctors with respect to the fees to be allowed for doctors' services under Foundation Plans.

It repeats its response to Statement 44.

47. The Foundation has consulted with various groups of doctors with respect to the unit conversion factor(s) to be used to determine the fees allowed for doctors' services under Foundation Plans.

It repeats its response to Statement 44.

48. The Foundation has consulted with various groups of doctors with respect to the relative value schedule(s) their members use.

It repeats its response to Statement 44.

49. The Foundation has consulted with various groups of doctors with respect to the relative value schedule(s) their members perfer.

It repeats its response to Statement 44.

50. The Foundation has consulted with various groups of doctors with respect to the relative value schedule(s) to be used by the Foundation.

It repeats its response to Statement 44.

51. The Foundation has asked various groups of doctors to poll their members with respect to the fees they usually charge for their services.

It repeats its response to Statement 44.

52. The Foundation has asked various groups of doctors to poll their members with respect to the unit conversion factor(s) they use to determine the fees for their services.

It repeats its response to Statement 44.

53. The Foundation has asked various groups of doctors to poll their members with respect to the fees to be allowed for doctors' services under Foundation Plans.

It repeats its response to Statement 44.

54. The Foundation has used the information obtained from surveys of doctors in preparing Foundation fee schedules.

It admits that it has used information obtained from surveys of doctors to advise it in connection with its determination of maximum reimbursable levels of compensation to doctors providing medical services to patients insured under Foundation-endorsed health insurance plans to be proposed to its members for adoption.

55. The Foundation has sent proposed Foundation fee schedules to Foundation members for their approval.

It repeats its responses to Statements 34 and 36.

56. Foundation fee schedules have been approved by wide margins.

It does not know what is meant by this statement and objects to it as vague and ambiguous.

57. The Foundation has sent copies of adopted Foundation fee schedules to Foundation members.

It admits that it has sent its members lists of conversion factors used by it to determine maximum reimbursable levels of compensation to doctors providing medical services to patients insured under Foundation-endorsed health insurance plans.

58. The Foundation has sent copies of Foundation fee schedules to doctors who are not Foundation members.

It admits that it has sent copies of current Foundation conversion factors used by it to determine maximum reimbursable levels of compensation to doctors providing medical services to patients insured under Foundation-endorsed health insurance plans to non-member doctors who request membership information and applications.

59. The Society has published, circulated or distributed reports on Foundation activities to Society members.

No knowledge.

60. The Society has published, circulated or distributed Foundation fee schedules to Society members.

No knowledge.

61. The Foundation has provided advance notice of expected increases in Foundation fee schedules to insurers that underwrite Foundation Plans.

It admits that its practice is to advise insurers underwriting health insurance plans endorsed by the Foundation in advance of expected changes to maximum reimbursable levels of compensation to doctors providing medical services to patients insured under Foundation-endorsed health insurance plans.

62. The Foundation has revised its minimum standards to require the coverage of additional doctors' services.

It admits that it has on occasion revised its "minimum standards for Foundation-endorsed group insurance plans," and that those revisions sometime require insurance for additional medical procedures.

63. The Maricopa Foundation has sent the Pima Foundation copies of fee schedules adopted by the Maricopa Foundation.

it admits that it has received from the Maricopa Foundation conversion factors used by the Maricopa Foundation to determine maximum reimbursable levels of compensation to doctors providing medical services to patients insured under Maricopa Foundation-endorsed health insurance plans.

64. The Foundation has administered the review and payment of claims submitted by Foundation policyholders.

It admits only that with respect to some health insurance plans endorsed by it, it has administered both peer review and claims payments on behalf of the insurer.

65. Foundation members submit assigned claims for services, goods or products sold to Foundation policyholders directly to the Foundation.

It admits that with respect to some health insurance plans endorsed by it, its members may submit assigned claims for doctors' services provided patients insured under those plans to it.

66. Foundation members receive payment of assigned claims for services, goods or products sold to Foundation policyholders directly from the Foundation.

It admits only that with respect to some health insurance plans endorsed by it, it writes drafts on the insurer's account as agent of the insurer to pay assigned claims from participating and cooperating members of the Foundation. It admits only that its members are assigned payment on some Foundation-endorsed health insurance policies and that it has supplied to members a preferred claim form for their use.

67. Foundation members submit assigned claims for services, goods or products sold to Foundation policyholders on uniform claim forms provided by the Foundation.

It admits that its members are assigned payments on some Foundation-endorsed health insurance policies and it has supplied to members a preferred claim form for their use.

68. The Maricopa Foundation and Pima Foundation use the same uniform claim form.

Denied.

69. The uniform claim form used by the Foundation calls for the doctor's usual fee for the service(s), good(s) or product(s) sold to Foundation policyholders.

It admits only that the claim forms approved for use by its members have spaces for setting forth the usual and customary fee they have billed to the patient.

70. Foundation members review claims submitted under Foundation Plans to determine the necessity of doctors' services to Foundation policyholders.

It admits only that its peer review function is performed with respect to claims submitted by the insurers to it for reimbursement for services performed by them on Foundation-insured patients to determine if those services were medically necessary or appropriate.

71. Foundation members review claims submitted under Foundation Plans to determine the payment(s) allowed for doctors' services to Foundation policyholders.

It admits that its members review claims submitted for services performed on patients insured under Foundation-approved plans to determine if the services were medically necessary or appropriate and if they were adequately described in the claim.

72. Approximately five per cent of Foundation members charge less than the maximum fee allowed for their services to Foundation policyholders.

No knowledge.

73. Criteria for the review of doctors' services to Foundation policyholders have been prepared by doctors who specialize in those services.

Denied.

74. The Foundation charges the insurers that underwrite Foundation Plans a service fee for the review and processing of claims.

It admits only that it charges insurers that underwrite Foundation-endorsed health insurance plans a fee when it provides peer review and claims process service for the insurer.

75. The Maricopa Foundation and the Pima Foundation have cooperated in the review and processing of claims on certain Foundation Plans, including the State of Arizona Plan.

It admits that with respect to some health insurance plans endorsed by it, it was engaged by the Maricopa Foundation to perform peer review and claims processing service as an agent of the Maricopa Foundation for the insurer with respect to claims submitted for services performed by doctors in Pima County.

76. In August, 1975, the Maricopa Foundation was paying the salary of at least one employee of the Pima Foundation.

It admits only that for a time including August, 1975, it was paid by the Maricopa Foundation the salary of at least one Pima Foundation employee engaged in the activities described in the response to Statement 75.

77. You do not underwrite the actuarial risk of Foundation Plans.

Admitted, as to it.

78. You do not indemnify Foundation policyholders for the cost of services covered by Foundation Plans.

It admits only that its members agree to accept as payment in full of their bills to patients insured under Foundation-endorsed medical insurance plans the maximum reimbursable levels of compensation for medical services provided those patients if those maximum reimbursable levels of compensation are less than their bills, and it states that the doctors who are not members are not so bound.

79. You have not applied to the Director of Insurance of the State of Arizona for a certificate of authority to transact insurance in the State of Arizona pursuant to A.R.S. Section 20-216.

Admitted.

80. You have not been issued a certificate of authority to transact insurance in the State of Arizona pursuant to A.R.S. Section 20-216.

Admitted.

81. You have not applied to the Director of Insurace of the State of Arizona for a license to act as an agent, general agent, broker or solicitor pursuant to A.R.S. Section 20-287, 20-290, 20-291 or 20-295.

Admitted.

82. You have not been issued a license to act as an agent, general agent, broker or solicitor pursuant to A.R.S. Section 20-287, 20-290, 20-291 or 20-295.

Admitted.

86. You have not been issued a certificate of authority to establish or operate a health care services organization pursuant to A.R.S. Section 20-1051 or 20-1052.

Admitted.

* * * *

STATEMENTS TO BE ADMITTED BY DEFENDANTS PIMA SOCIETY AND PIMA FOUNDATION

316. The Foundation was founded in or about February, 1971.

Admitted.

317. The Foundation was founded to promote the practice of medicine on a fee for service basis in the area of Pima County, Arizona.

Admitted.

318. On or about March 1, 1971, the Foundation's Fee Schedule Committee agreed to use the 1969 edition of the California Relative Value Schedule to determine fees allowed for doctors' services under Foundation Plans.

Admitted.

319. In or about March, 1971, the Chairman of the Foundation's Fee Schedule Committee asked various groups of doctors if the Foundation's use of the 1969 edition of the California Relative Value Shedule was agreeable to their members.

Admitted.

320. In or about March, 1971, the Chairman of the Foundation's Fee Schedule Committee asked various groups of doctors what unit conversion factors their members wanted for the Foundation fee schedule.

Admitted.

321. On or about March 15, 1971, a group of Tucson anesthesiologists reported to the Foundation that its members were using the 1970 edition of the relative value schedule prepared by the American Society of Anesthesiologists.

Admitted.

322. In or about March and April of 1971, a group of Tucson anesthesiologists suggested that the Foundation use the 1970 edition of the relative value schedule prepared by the American Society of Anesthesiologists with a conversion factor of 8 for anesthesiology services.

Admitted.

323. After April of 1971, the Foundation used the 1970 edition of the relative value schedule prepared by the American Society of Anesthesiologists to determine allowable fees for anesthesiology services under Foundation Plans.

Admitted.

324. On or about March 17, 1971, the Tucson Psychiatric Society reported to the Foundation that its members were using the fee schedule adopted by the Industrial Commission of Arizona.

Admitted.

325. On or about April 6, 1971, the Chairman of the Foundation's Fee Schedule Committee met with members of the Tucson Psychiatric Society to discuss the Foundation fee schedule.

No information.

326. On or about March 18, 1971, a group of Tucson urologists recommended that the Foundation use a unit conversion factor of 27.5 with the 1969 edition of the California Relative Value Schedule.

Admitted.

327. On or about May 4, 1971, a group of Tucson urologists recommended to the Foundation that the relative value schedule prepared by the American Urologists Association (AUA) be used to determine allowable fees for urological services under Foundation Plans.

Admitted.

328. On or about March 23, 1971, a group of Tucson ophthalmologists reported to the Foundation that they had agreed to accept the 1969 edition of the California Relative Value Schedule with unit conversion factors of $25.00 for surgery and .50 for medicine.

Admitted.

329. On or about April 12, 1971, a group of Tucson neurologists reported to the Foundation that its members were using the 1969 edition of the California Relative Value Schedule with a conversion factor of 26.

Admitted.

330. On or about April 19, 1971, a group of Tucson orthopedic surgeons reported to the Foundation that they would accept the 1969 edition of the California Relative Value Schedule.

Admitted.

331. On or about April 22, 1971, a group of Tucson radiologists reported to the foundation that its members were using the 1969 edition of the relative value schedule prepared by the American College of Radiology with a unit conversion factor of 6.

Admitted.

332. On or about April 22, 1971, a group of Tucson radiologists reported to the Foundation their acceptance of the Foundation's proposed conversion factor of 6.5 for radiological services.

Admitted.

333. On or about April 22, 1971, the Southern Arizona Chapter of the American Academy of General Practice informed the Foundation that its members had agreed to use the 1969 California Relative Value Schedule.

Admitted.

334. On or about May 7, 1971, the agreement of Tucson internists to use the 1969 edition of the California Relative Value Schedule with a conversion factor of .75 for medicine was reported to the Foundation.

Admitted.

335. In or about June, 1971, the Tucson Psychiatric Society reported to the Foundation that its members had agreed to the use of the 1969 edition of the California Relative Value Schedule with a conversion factor of .75.

Admitted.

336. In or about June, 1971, the Tucson Psychiatric Society suggested to the Foundation that a conversion factor of .775 would be appropriate by the fall of 1971.

Admitted.

337. On or about October 25, 1971, the Foundation's minimum standards became effective.

Admitted.

338. On or about October 25, 1971, the Foundation's first fee schedule became effective.

Admitted.

339. On or about June 5, 1973, the Foundation's President was a guest speaker at a meeting of the Tucson Psychiatric Society.

No information.

340. On or about June 5, 1973, the Foundation's President asked members of the Tucson Psychiatric Society to inform the Foundation of the fees and coverage for psychiatric services which they considered desirable.

No information.

341. Beginning on or about June 5, 1973, representatives of the Foundation consulted with representatives of the Tucson Psychiatric Society concerning coverage and fees for psychiatric services.

No information.

342. In or about 1973, the Foundation adopted the Maricopa Foundation's fee schedule for covered psychiatric services.

Denied.

343. On or about August 29, 1973, the Foundation's Fee Schedule Committee met to discuss possible increases in the Foundation fee schedule.

Admitted.

344. The Foundation fee schedule effective in 1973 included unit conversion factors of:

(a) 8 for medicine;
(b) 7 for surgery;
(c) 5.50 for laboratory;
(d) 8 for anesthesiology.
(e) 7 for radiology.

Admitted.

345. In or about December, 1973, the Foundation prepared a proposed fee schedule for 1974.

Admitted.

346. In or about December, 1973, the Foundation sent a proposed Foundation fee schedule for 1974 to Foundation members for approval.

Admitted.

347. By about January 7, 1974, most Foundation members had approved the Foundation fee schedule for 1974.

Admitted.

348. By February 12, 1974, the Foundation had adopted the Foundation fee schedule for 1974.

Admitted.

349. The Foundation fee schedule for 1974 included unit conversion factors of:

(a) 8.50 for medicine;
(b) 7.50 for surgery;
(c) 5.70 for laboratory;
(d) 8.50 for anesthesiology;
(e) 7.50 for radiology with a professional component of 1.70.

Admitted.

350. By February 12, 1974, the Foundation had mailed copies of the Foundation fee schedule for 1974 to Foundation members.

Admitted.

351. In or about August, 1974, an article describing the Foundation was published in the *Sombrero*.

No information.

352. In or about August, 1974, the *Sombrero* reported that the Foundation fee schedule was based upon the 1964 edition of the California Relative Value Schedule.

No information.

353. In or about August, 1974, the *Sombrero* published the Foundation fee schedule for 1974.

No information.

354. The *Sombrero* is a regular publication of the Society.

No information.

355. The *Sombrero* is published, circulated or distributed to Society members.

No information.

356. On or about October 24, 1974, the Chairman of the Foundation's Fee Schedule Committee sent to Foundation members the fee schedule adopted by the Maricopa Foundation effective November 1, 1974.

Admitted.

357. On or about October 24, 1974 the Chairman of the Foundation's Fee Schedule Committee notified Foundation members that the fee schedule adopted by the Maricopa Foundation effective November 1, 1974 had also been recommended to the Industrial Commission of Arizona.

Admitted.

358. On or about October 24, 1974, the Chairman of the Foundation's Fee Schedule Committee notified Foundation members that the fee schedule adopted by the Maricopa Foundation effective November 1, 1974 could be adopted as the Pima Foundation fee schedule if the Foundation members signed the enclosed approval form.

Admitted.

359. By approximately December 9, 1974, Foundation members had approved the fee schedule sent to them by the Chairman of the Foundation's Fee Schedule Committee on or about October 24, 1974.

Admitted.

360. On or about January 30, 1975, the Foundation polled Foundation members concerning the Foundation fee schedule for 1975.

Admitted.

361. The Foundation fee schedule for 1975 coincided exactly with the fee schedule adopted by the Maricopa Foundation for 1975.

Admitted.

362. By approximately February 11, 1975 Foundation members had approved the 1975 fee schedule of the Maricopa Foundation as the Pima Foundation fee schedule for 1975.

Admitted.

363. The Foundation fee schedule for 1975 was adopted by a vote of approximately 119 to 9.

Admitted.

364. The Foundation fee schedule for 1975 included unit conversion factors of:

(a) 10 for medicine;
(b) 8.50 for surgery;
(c) 6.50 for laboratory;
(d) 10 for anesthesiology;
(e) 7.50 for radiology with a professional component of 1.70.

Admitted.

365. On or about April 2, 1976, the Foundation sent Foundation members copies of a proposed fee schedule for pediatric services.

Admitted.

366. The Foundation's proposed fee schedule for pediatric services was based on usual or customary doctors' fees for pediatric services in the Pima County area.

Admitted.

367. On or about April 2, 1975, the Vice President of the Foundation notified Foundation members of Foundation coverage of preventative health services under a Foundation Plan.

Admitted.

368. On or about April 2, 1975, the Vice President of the Foundation sent Foundation members a fee schedule to be used for preventative health services.

Admitted.

369. On or about June 9, 1975, the Foundation's Board of Trustees agreed not to approve Foundation Plans underwritten by Blue Shield of Arizona if Blue Shield also submitted bids for indemnity insurance or health maintenance organization plans to the same prospective subscriber.

Admitted: that such action has since been rescinded.

370. Until about July 1, 1975, the principal place of business of the Foundation and the principal place of business of the Society were located in the same building in Tucson, Arizona.

Admitted.

371. In or about September, 1975, the Foundation employed an Executive Director who had employment experience with the California Medical Association and the Medical Care Foundation of Sacramento.

Admitted.

372. On or about September 1, 1975, the *Sombrero* published the Foundation fee schedule.

No information.

373. In or about September, 1975, approximately 75 percent of the doctors practicing in Pima County, Arizona were members of the Foundation.

No information.

374. In or about November, 1975, approximately 80 percent of the doctors practicing in Pima County, Arizona were members of the Foundation.

No information.

375. In or about November, 1975, the Foundation sent copies of the Foundation fee schedule to Foundation members.

Admitted.

376. Beginning about November 12, 1975, the Foundation reviewed and paid claims for doctors' fees under Foundation Plans written by Blue Cross and Blue Shield of Arizona, Pacific Mutual Insurance Company and Connecticut General Insurance Company.

Denied.

377. On or about November 18, 1975, the Society executed a Memorandum of Understanding with the Foundation and Blue Cross and Blue Shield of Arizona with respect to the Society's group insurance trust.

Denied.

378. On or about November 26, 1975, the Foundation received a fee schedule prepared by the Foundation for Medical Care of Sacramento, California.

Admitted.

379. On or about January 9, 1976, the Chairman of the Foundation's Fee Schedule Committee sent a proposed Foundation fee schedule for 1976 to the Foundation's Board of Trustees.

Admitted.

380. On or about January 10, 1976, a representative of the Foundation attended a meeting of the Board of Directors of the Arizona Medical Association at which the President of the Maricopa Foundation described the Maricopa Foundation's development of a relative value schedule for Arizona doctors.

No information.

381. On or about January 12, 1976, the Foundation's Board of Trustees appointed certain doctors to a Minimum Standards Committee to update the Foundation's minimum standards.

Admitted.

382. On or about January 12, 1976, the Foundation's Board of Trustees approved a recommended Foundation fee schedule for 1976.

Admitted.

383. On or about January 27, 1976, the Society's Board of Directors adjourned its regular meeting and thereafter convened a meeting as administrative members of the Foundation.

No information.

384. On or about January 27, 1976, the Society's Board of Directors approved a slate of officers and by-law amendments for the Foundation.

No information.

385. On or about February 9, 1976, the Foundation's Board of Trustees disbanded the Foundation's Nominations Committee, Fee Schedule Committee and Minimum Standards Committee.

Admitted.

386. On or about February 9, 1976, the Foundations Board of Trustees directed that the Foundation's Executive Comittee act in the capacity of the Nominations Committee, Fee Schedule Committee and Minimum Standards Committee.

Admitted.

387. On or about February 10, 1976, annual premiums on Foundation Plans totalled approximately $576,304.

Admitted.

388. On or about April 8, 1976, the Foundation agreed to perform certain administrative services for the Maricopa Foundation with respect to the State of Arizona Plan.

Admitted.

389. On or about April 12, 1976, the Foundation's Board of Trustees agreed to retain the Foundation fee schedule for 1975 until an expected 20 percent increase in indemnity insurance premiums occurred.

Denied.

390. On or about April 12, 1976, the Foundation's Board of Trustees agreed to review the Foundation fee schedule in May, 1976.

Admitted.

391. In or about April, 1976, the *Sombrero* announced that the Foundation would maintain its 1975 fee schedule through May, 1976.

No information.

392. In or about April, 1976, the *Sombrero* announced that in May, 1976 the Foundation would, as usual, conduct a study to determine the new Foundation fee schedule.

No information.

393. On or about April 12, 1976, the Foundation's Board of Trustees established a Fee Committee.

Admitted.

394. On or about April 12, 1976, the Foundation's Board of Trustees discussed the suggestion of the Maricopa Foundation that the Pima Foundation use the same fee schedule as that adopted by the Maricopa Foundation.

Denied.

395. In or about April, 1976, two representatives of the Foundation attended a meeting in Oakland, California concerning activities of foundations for medical care.

Admitted.

396. On or about May 10, 1976, the Chairman of the Foundation's Fee Schedule Committee presented a proposed Foundation fee schedule for 1976 to the Foundation's Board of Trustees.

Admitted.

397. On or about May 10, 1976, the Foundation adopted the uniform claim form used by the Maricopa Foundation.

No information.

398. On or about May 10, 1976, the Foundation's Board of Trustees decided to use the Foundation's fee schedule for 1976 with an increase in the unit conversion factor for radiology to 8.

Admitted.

399. On or about May 10, 1976, the Foundation's Board of Trustees decided to increase the unit value used by the Foundation for an office visit from 1.0 to 1.3.

Admitted.

400. On or about May 10, 1976, the Foundation's Board of Trustees decided to begin work on the Foundation's fee schedule for 1977 by November of 1976.

Admitted.

401. On or about May 12, 1976, the Foundation's Executive Director sent local counsel for the Foundation the names of two antitrust lawyers.

Admitted.

402. On or about May 17, 1976, the Foundation's Board of Trustees sent Foundation members the proposed Foundation fee schedule for 1976 with an enclosed mail ballot for approval of that schedule.

Admitted.

403. By about June 14, 1976, Foundation members approved the Foundation fee schedule for 1976 by a vote of approximately 262 to 24.

Admitted.

404. On or about October 7, 1976, the Foundation's Minimum Standards Committee presented recommendations for revisions in the minimum standards to the Foundation's Board of Trustees.

Admitted.

405. On or about October 11, 1976, the Foundation's Board of Trustees accepted the report of the Chairman of the Minimum Standards Committee.

Admitted.

406. On or about October 11, 1976, the Foundation's Board of Trustees approved the changes and additions in the Foundation's minimum standards recommended by the Chairman of the Foundation's Minimum Standards Committee.

Admitted.

407. On or about October 7, 1976, the Chairman of the Foundation's Fee Schedule Committee presented a proposed Foundation fee schedule for 1977 to the Foundation's Board of Trustees.

Admitted.

408. On or about October 11, 1976, the Foundation's Board of Trustees approved the proposed Foundation fee schedule for 1977 which was recommended to the Board by the Chairman of the Foundation's Fee Schedule Committee.

Admitted.

409. On or about October 11, 1976, the Foundation's Board of Trustees sent Foundation members the proposed Foundation fee schedule for 1977.

Admitted.

410. On or about October 11, 1976, the Foundation's Board of Trustees notified Foundation members that the unit value used by the Foundation for an office visit had been increased from 1.0 to 1.3.

Admitted.

411. On or about October 18, 1976, the Foundation sent the proposed Foundation fee schedule for 1977 and revisions in the Foundation's minimum standards to Blue Shield of Arizona.

No information.

412. By about November 8, 1976, Foundation members approved the Foundation fee schedule for 1977 by a vote of approximately 178 to 10.

Admitted.

413. The Foundation fee schedule for 1977 includes unit conversion factors of:

(a) 11 for medicine;

(b) 9.50 for surgery;

(c) 7 for laboratory;

(d) 12 for anesthesiology;

(e) 8.50 for radiology with a professional component of 1.80.

Admitted.

414. On or about November 8, 1976, the Tucson Pediatric Society agreed to a fee schedule for well baby care proposed by the Foundation.

Admitted.

415. The Foundation fee schedule proposed in 1976 for well-baby care consisted of a conversion factor of 11.

Denied.

416. On or about November 23, 1976, the Society's Board of Directors approved the election of members of the Foundation's Board of Trustees.

Admitted.

417. On or about January 1, 1977, the Foundation's revised minimum standards became effective.

Admitted.

418. On or about January 21, 1977, the Foundation's Board of Trustees directed the Foundation's Peer Review Committee to reimburse fees for office visits according to the unit values provided in the 1974 edition of the California Relative Value Schedule.

Denied.

419. On or about November 21, 1977, Foundation's Fee Schedule Committee informed the Foundation's Board of Trustees that the Foundation fee schedule was lower than the fee schedules of the Maricopa Foundation and the Industrial Commission of Arizona.

Admitted.

420. On or about November 21, 1977, the Foundation's Board of Trustee directed that a Foundation committee study the Foundation fee schedule.

Admitted.

421. On or about November 21, 1977, the Foundation's Board of Trustees directed that a committee report to the Board by December 12, 1977 concerning a revised Foundation fee schedule for 1978.

Admitted.

422. On or about December 12, 1977, the Chairman of the Foundation's Fee Schedule Committee presented a proposed Foundation fee schedule for 1978 to the Foundation's Board of Trustees.

Admitted.

423. On or about December 13, 1977, the Foundation's Board of Trustees sent a proposed Foundation fee schedule for 1978 to Foundation members with an enclosed mail ballot for approval of that fee schedule.

Admitted.

424. On or about December 13, 1977, the Foundation's Board of Trustees reminded Foundation members that the unit value used by the Foundation for an office visit was 1.3.

Admitted.

425. On or about January 16, 1978, the Chairman of the Foundation's Fee Schedule Committee informed the Foundation's Board of Trustees that Foundation members had approved the Foundation fee schedule for 1978.

Admitted.

426. The Foundation fee schedule for 1978 includes unit conversion factors of:

(a) 11.75 for medicine;
(b) 10.00 for surgery;
(c) 7.40 for laboratory;

(d) 13.00 for anesthesiology.

(e) 9.00 for radiology with a professional component of 2.00.

Admitted.

427. On or about January 31, 1978, the Society's Board of Directors elected a new slate of members of the Foundation's Board of Trustees.

Denied.

428. The Society is an association of doctors in Pima County, Arizona.

Admitted.

* * * *

EXHIBIT B

(Caption omitted in printing.)

PLAINTIFF'S FIRST
REQUEST FOR ADMISSIONS
AND INTERROGATORIES
AND RESPONSES OF DEFENDANT
MARICOPA FOUNDATION FOR
MEDICAL CARE

* * * *

STATEMENTS TO BE ADMITTED BY ALL DEFENDANTS

1. The Foundation has four classes of membership: administrative, participating, cooperating and PSRC.

The Maricopa Foundation only admits that the Maricopa Foundation has four classes of membership: administrative, participating, cooperating and health care institution participating members and states it has no information sufficient to admit or deny this statement with respect to Pima Foundation.

2. The members of the Board of Directors of the Society are elected by the members of the Society.

The Maricopa Foundation has no information sufficient to admit or deny the truth or falsity of this statement and refers plaintiff to the responses provided by defendants Maricopa Society and Pima Society.

3. The Members of the Board of Directors of the Society automatically become administrative members of the Foundation.

The Maricopa Foundation only admits that, pursuant to the By-Laws of Maricopa Foundation, every person, upon becoming a member of the Board of Directors of the Maricopa Society is entitled to become and, without further

action or proceeding, becomes an administrative member of the Maricopa Foundation and states it has no information sufficient to admit or deny this statement with respect to Pima Foundation.

4. Administrative members are the only class of members in the Foundation having a general voting power.

The Maricopa Foundation only admits that the only class of members of the Maricopa Foundation with the privilege of voting in the Maricopa Foundation is administrative members except that participating and cooperating members have the right to vote on the adoption of maximum reimbursable levels of compensation to doctors providing medical services to patients insured under Maricopa Foundation-endorsed health insurance plans and that the Board of Trustees of Maricopa Foundation has full and sole power to control and manage the property and conduct the affairs and business of Maricopa Foundation and have general voting power with respect thereto and states it has no information sufficient to admit or deny this statement with respect to Pima Foundation.

5. As the administrative members of the Foundation, the members of the Board of Directors of the Society elect or appoint the members of the Board of Trustees of the Foundation.

The Maricopa Foundation only admits that the administrative members of the Maricopa Foundation elect the Board of Trustees of the Maricopa Foundation and states it has no information sufficient to admit or deny this statement with respect to Pima Foundation.

6. Foundation Plans are underwritten by private insurers which are located in the State of Arizona and elsewhere.

The Maricopa Foundation only admits that some Maricopa Foundation-endorsed plans are underwritten by private insurers, each such private insurer does business from

a location in Arizona and at least some do business from locations outside Arizona and states it has no information sufficient to admit or deny this statement with respect to Pima Foundation.

7. To obtain your endorsement as a Foundation Plan, a health insurance plan must comply with the minimum standards formulated by the Foundation.

The Maricopa Foundation only admits that it will not endorse a health insurance plan unless it meets minimum standards for foundation-endorsed group insurance programs formulated by Maricopa Foundation or Maricopa Foundation agrees in writing to a modification of those standards.

8. Minimum standards for Foundation Plans are approved by the Board of Trustees of the Foundation.

The Maricopa Foundation only admits that minimum standards for Maricopa Foundation-endorsed health insurance plans are determined and approved by the Board of Trustees of Maricopa Foundation and states it has no information sufficient to admit or deny this statement with respect to Pima Foundation.

9. Minimum standards for Foundation Plans include, among other things, the doctors' services to be covered under Foundation Plans.

The Maricopa Foundation only admits minimum standards for Maricopa Foundation-endorsed health insurance plans include a list of medical services for which the insurer is required to provide reimbursement to insured patients and states it has no information sufficient to admit or deny this statement with respect to Pima Foundation.

10. Minimum standards for Foundation Plans include, among other things, the allowable rate of payment for covered services, goods and products sold by doctors to Foundation policyholders.

The Maricopa Foundation only admits that its "Minimum Standards for Foundation-Endorsed Group Insurance Programs" includes a maximum reimbursable payment schedule with respect to payments by the insurer to doctors for services provided to patients insured under Maricopa Foundation-endorsed health insurance plans and states it has no information sufficient to admit or deny this statement with respect to Pima Foundation.

11. The Foundation has entered into agreements with insurers in which the insurer agreed to comply with the Foundation's minimum standards.

The Maricopa Foundation only admits that is has entered into agreements with insurers pursuant to which those insurers agree to write health insurance for certain groups which is not inconsistent with Maricopa Foundation's "Minimum Standards for Foundation-Endorsed Group Insurance Plans" and states it has no information sufficient to admit or deny this statement with respect to Pima Foundation.

12. The Foundation has entered into agreements with insurers that insurers will pay for services, goods and products sold by doctors to Foundation policy holders at prices up to the amount set in the Foundation fee schedule.

The Maricopa Foundation only admits that it has entered into agreements with insurers wherein insurers agreed to reimburse doctors for services rendered to patients insured under Maricopa Foundation-endorsed health insurance plans in accordance with their usual and customary fees charged for such services but not to exceed the maximum reimbursable level of compensation set forth in the Maricopa Foundation's "Minimum Standards for Foundation-Endorsed Group Insurance Programs" except at the insurer's discretion and states it has no information sufficient to admit or deny this statement with respect to Pima Foundation.

13. The Foundation's participating and cooperating members execute applications for membership in the Foundation each year.

The Maricopa Foundation only admits that the Maricopa Foundation enters membership agreements with its participating and cooperating members annually and states it has no information sufficient to admit or deny this statement with respect to Pima Foundation.

14. Applications for participating and cooperating membership have contained a provision that the Foundation member will be bound by the fee schedules adopted by Foundation members.

The Maricopa Foundation only admits that its membership agreements with its participating and cooperating membership have provided that those members agree to be bound during the period of membership applied for with respect to services provided to patients insured under Maricopa Foundation-endorsed plans to accept a determination by the Maricopa Foundation consistent with the schedule adopted by the membership for determining the maximum reimbursable payment as full payment of fees for medical services rendered by them to such patients unless the patient refused to assign benefits to the member or has multiple health insurance coverage and states it has no information sufficient to admit or deny this statement with respect to Pima Foundation.

15. Foundation members agree to accept the payment allowed by the Foundation fee schedule as full compensation on assigned claims for the covered services, goods and products which they sell to Foundation policyholders.

The Maricopa Foundation repeats its response to statement 14.

16. Unless a Foundation policyholder has assigned his or her benefits under a Foundation Plan in advance, Foundation members are not obligated to accept the payments allowed by the Foundation fee schedule as full payment for services to that Foundation policyholder.

The Maricopa Foundation repeats its response to statement 14 and further states that pursuant to the minimum standards for foundation-endorsed group insurance programs assignment of benefits by insureds to doctors who are foundation members is automatic.

17. To determine the fee allowed for a doctor's service under a Foundation Plan, one must refer to both a relative value schedule and a unit conversion factor.

The Maricopa Foundation only admits that to determine the maximum reimbursable payment to a doctor for services provided to a patient insured under a Maricopa Foundation-endorsed health insurance plan, one must refer both to a relative value schedule and a conversion factor and peer review determines that the services are medically necessary or appropriate and states it has no information sufficient to admit or deny this statement with respect to Pima Foundation.

18. The Foundation selects the relative value schedule(s) used to determine the fees allowed for doctors' services under Foundation Plans.

The Maricopa Foundation only admits that the Maricopa Foundation has prepared relative value schedules used to determine the maximum reimbursable levels of compensation payable by the insurer to doctors for services provided to patients insured under Maricopa Foundation-endorsed health insurance plans and states it has no information sufficient to admit or deny this statement with respect to Pima Foundation.

19 The Foundation has used a relative value schedule prepared by the California Medical Association.

The Maricopa Foundation only admits that relative value chedules prepared and used by Maricopa Foundation are ased in part upon the 1964 edition of the relative value chedule adopted by the California Medical Association and tates it has no information sufficient to admit or deny this tatement with respect to Pima Foundation.

20. The California Medical Association no longer revises r publishes a relative value schedule.

The Maricopa Foundation has no information sufficient o admit or deny the truth or falsity of this statement.

21. The Foundation has used a relative value schedule repared by the American Society of Anesthesiologists.

The Maricopa Foundation only admits that relative value chedules prepared and used by Maricopa Foundation are ased in part upon relative value schedules adopted by the merican Society of Anesthesiologists and states it has no nformation sufficient to admit or deny this statement with espect to Pima Foundation.

22. The American Society of Anesthesiologists no longer evises or publishes a relative value schedule.

The Maricopa Foundation has no information sufficient o admit or deny the truth or falsity of this statement.

23. The Foundation has used a relative value schedule repared by the American College of Radiology.

The Maricopa Foundation only admits that relative value chedules prepared and used by Maricopa Foundation are ased in party upon relative value schedules adopted by the merican College of Radiology and states it has no infor- nation sufficient to admit or deny this statement with espect to Pima Foundation.

24. The American College of Radiology no longer revises r publishes a relative value schedule.

The Maricopa Foundation has no information sufficient o admit or deny the truth or falsity of this statement.

25. The Foundation has been informed that agencies of the Federal Government which enforce the federal antitrust laws consider the preparation and publication of a relative value schedule to be a violation of the federal antitrust laws.

Denied as to Maricopa Foundation. Maricopa Foundation states it has no information sufficient to admit or deny this statement with respect to Pima Foundation.

26. The Foundation has been informed that agencies of the Federal Government which enforce the federal antitrust laws consider the use by doctors of a relative value schedule to be a violation of the federal antitrust laws.

Denied as to Maricopa Foundation. Maricopa Foundation states it has no information sufficient to admit or deny this statement with respect to Pima Foundation.

27. The Foundation has been informed of legal action taken by agencies of the Federal Government against associations of doctors which have revised and published a relative value schedule.

The Maricopa Foundation objects to this statement on the bases that it is vague and ambiguous and beyond the scope of discovery permitted by Rules 26(b) and 36 of the Federal Rules of Civil Procedure.

28. The Foundation has revised relative value schedules.

The Maricopa Foundation only admits that it has revised its relative value schedules and states it has no information sufficient to admit or deny this statement with respect to Pima Foundation.

29. The Maricopa Foundation prepared a relative value schedule for use in Arizona.

The Maricopa Foundation only admits that it has prepared relative value schedules for use in Arizona to determine the maximum reimbursable levels of compensation payable by the insurer to doctors for services provided to patients insured under Maricopa Foundation-endorsed health insurance plans.

30. The Maricopa Foundation prepared a document entitled "Arizona Medical Services Terminology and Descriptive Index."

Denied.

31. The Foundation uses the Arizona Medical Services Terminology and Descriptive Index.

Denied as to Maricopa Foundation. Maricopa Foundation states it has no information sufficient to admit or deny this statement with respect to Pima Foundation.

32. The Foundation has increased unit values used to determine the fees allowed for some doctors' services under Foundation Plans.

The Maricopa Foundation only admits that it has in some instances increased and in some instances decreased the unit value used to determine the maximum reimbursable level of compensation payable by the insurer to doctors for services provided to a patient insured under a Maricopa Foundation-endorsed health insurance plan and states it has no information sufficient to admit or deny this statement with respect to Pima Foundation.

33. The Foundation fee schedule sets the unit conversion factors used to determine the fees allowed for doctors' services under Foundation Plans.

Denied as to Maricopa Foundation. Maricopa Foundation states it has no information sufficient to admit or deny this statement with respect to Pima Foundation.

34. Foundation members have the power to vote on the unit conversion factors used to determine the fees allowed for doctors' services under Foundation Plans.

Maricopa Foundation only admits that its participating and cooperating members have the right to vote on the adoption of maximum reimbursable levels of compensation to doctors providing medical services to patients insured under Maricopa Foundation-endorsed health insurance plans, including adoption of conversion factors used with relative value schedules for that purpose and states it has no information sufficient to admit or deny this statement with respect to Pima Foundation.

35. Foundation fee schedules are adopted periodically by majority vote of Foundation members.

Denied as to Maricopa Foundation. Maricopa Foundation states it has no information sufficient to admit or deny this statement with respect to Pima Foundation. See response to statement 34.

36. Voting on Foundation fee schedules has been conducted by mail ballot.

Denied as to Maricopa Foundation. See response to statement 34. The voting referred to in response to statement 34 has been conducted by mail ballot. Maricopa Foundation states it has no information sufficient to admit or deny this statement with respect to Pima Foundation.

37. The Foundation has polled its members with respect to the fees they usually charge for their services.

The Maricopa Foundation only admits that it has surveyed its members as to their usual and customary fees for medical services and states it has no information sufficient to admit or deny this statement with respect to Pima Foundation.

38. The Foundation has polled its members with respect to the unit conversion factor(s) they use to determine the fees for their services.

The Maricopa Foundation only admits that it has surveyed its members as to what dollar conversion factors would approximate their usual and customary fees for medical services and states it has no information sufficient to admit or deny this statement with respect to Pima Foundation.

39. The Foundation has polled its members with respect to the fees to be allowed for doctors' services under Foundation Plans.

Denied as to Maricopa Foundation. See responses to statements 34 and 36. Maricopa Foundation states it has no information sufficient to admit or deny this statement with respect to Pima Foundation.

40. The Foundation has polled its members with respect to the unit conversion factors to be used to determine the fees allowed for doctors' services under Foundation Plans.

Denied as to Maricopa Foundation. See responses to statements 34 and 36. Maricopa Foundation states it has no information sufficient to admit or deny this statement with respect to Pima Foundation.

41. The Foundation has polled its members with respect to the relative value schedule(s) they use.

The Maricopa Foundation only admits that it has surveyed its members as to what relative value schedule they use for purposes of calculating the conversion factors which would approximate their usual and customary fees for medical services and states it has no information sufficient to admit or deny this statement with respect to Pima Foundation.

42. The Foundation has polled its members with respect to the relative value schedule(s) they prefer.

Denied as to Maricopa Foundation. See response to statement 41 and letters from the Maricopa Foundation to its members dated June 20, 1974, July 5, 1974, May 20, 1975, October 10, 1975 and October 27, 1975, copies of which were produced to plaintiff on April 7, 1978. Maricopa Foundation states it has no information sufficient to admit or deny this statement with respect to Pima Foundation.

43. The Foundation has polled its members with respect to the relative value schedule(s) to be used by the Foundation.

Denied as to Maricopa Foundation. See response to statement 42. Maricopa Foundation states it has no information sufficient to admit or deny this statement with respect to Pima Foundation.

44. The Foundation has consulted with various groups of doctors with respect to the fees their members usually charge for their services.

Maricopa Foundation only admits it has requested various professional organizations whose members are doctors to advise Maricopa Foundation in connection with Maricopa Foundation's determination of maximum reimbursable levels of compensation to doctors providing medical services to patients insured under Maricopa Foundation-endorsed health insurance plans to be proposed to Maricopa Foundation's participating and cooperating members for adoption and states it has no information sufficient to admit or deny this statement with respect to Pima Foundation.

45. The Foundation has consulted with various groups of doctors with respect to the unit conversion factor(s) their members use to determine the fees for their services.

Maricopa Foundation repeats its response to statement 44.

46. The Foundation has consulted with various groups of doctors with respect to the fees to be allowed for doctors' services under Foundation Plans.

Maricopa Foundation repeats its response to statement 44.

47. The Foundation has consulted with various groups of doctors with respect to the unit conversion factor(s) to be used to determine the fees allowed for doctors' services under Foundation Plans.

Maricopa Foundation repeats its response to statement 44.

48. The Foundation has consulted with various groups of doctors with respect to the relative value schedule(s) their members use.

Maricopa Foundation repeats its response to statement 44.

49. The Foundation has consulted with various groups of doctors with respect to the relative value schedule(s) their members prefer.

Maricopa Foundation repeats its response to statement 44.

50. The Foundation has consulted with various groups of doctors with respect to the relative value schedule(s) to be used by the Foundation.

Maricopa Foundation repeats its response to statement 44.

51. The Foundation has asked various groups of doctors to poll their members with respect to the fees they usually charge for their services.

Maricopa Foundation repeats its response to statement 44.

52. The Foundation has asked various groups of doctors to poll their members with respect to the unit conversion factor(s) they use to determine the fees for their services.

Maricopa Foundation repeats its response to statement 44.

53. The Foundation has asked various groups of doctors to poll their members with respect to the fees to be allowed for doctors' services under Foundation Plans.

Maricopa Foundation repeats its response to statement 44.

54. The Foundation has used the information obtained from surveys of doctors in preparing Foundation fee schedules.

The Maricopa Foundation only admits it has used information obtained from surveys of doctors to advise Maricopa Foundation in connection with its determination of maximum reimbursable levels of compensation to doctors providing medical services to patients insured under Maricopa Foundation-endorsed health insurance plans to be proposed to Maricopa Foundation's participating and cooperating members for adoption and states it has no information sufficient to admit or deny this statement with respect to Pima Foundation.

55. The Foundation has sent proposed Foundation fee schedules to Foundation members for their approval.

Maricopa Foundation repeats its responses to statements 34 and 36.

56. Foundation fee schedules have been approved by wide margins.

The Maricopa Foundation objects to this statement on the basis that it is vague and ambiguous.

57. The Foundation has sent copies of adopted Foundation fee schedules to Foundation members.

The Maricopa Foundation only admits that it has sent to its members lists of conversion factors used by it to determine maximum reimbursable levels of compensation to doctors providing medical services to patients insured under Maricopa Foundation-endorsed health insurance plans and states it has no information sufficient to admit or deny this statement with respect to Pima Foundation.

58. The Foundation has sent copies of Foundation fee schedules to doctors who are not Foundation members.

The Maricopa Foundation only admits that it has sent copies of current Maricopa Foundation conversion factors used by it to determine maximum reimbursable levels of compensation to doctors providing medical services to patients insured under Maricopa Foundation-endorsed health insurance plans to non-member doctors who request membership information and applications and states it has no information sufficient to admit or deny this statement with respect to Pima Foundation.

59. The Society has published, circulated or distributed reports on Foundation activities to Society members.

The Maricopa Foundation has no information sufficient to admit or deny the truth or falsity of this statement and refers plaintiff to the responses provided by the Maricopa Society and Pima Society.

60. The Society has published, circulated or distributed Foundation fee schedules to Society members.

The Maricopa Foundation has no information sufficient to admit or deny the truth or falsity of this statement and refers plaintiff to the responses provided by the Maricopa Society and Pima Society.

61. The Foundation has provided advance notice of expected increases in Foundation fee schedules to insurers that underwrite Foundation Plans.

The Maricopa Foundation only admits that its practice is to advise insurers underwriting health insurance plans endorsed by Maricopa Foundation in advance of expected changes to maximum reimbursable levels of compensation to doctors providing medical services to patients insured under Maricopa Foundation-endorsed health insurance plans and states it has no information sufficient to admit or deny this statement with respect to Pima Foundation.

62. The Foundation has revised its minimum standards to require the coverage of additional doctors' services.

The Maricopa Foundation only admits that on occasion it has revised its "Minimum Standards for Foundation-Endorsed Group Insurance Plans" and that those revisions sometimes require insurance for additional medical procedures.

63. The Maricopa Foundation has sent the Pima Foundation copies of fee schedules adopted by the Maricopa Foundation.

The Maricopa Foundation only admits it has sent to Pima Foundation conversion factors used by Maricopa Foundation to determine maximum reimbursable levels of compensation to doctors providing medical services to patients insured and Maricopa Foundation-endorsed health insurance plans.

64. The Foundation has administered the review and payment of claims submitted by Foundation policyholders.

The Maricopa Foundation only admits that with respect to some health insurance plans endorsed by Maricopa Foundation, it has administered both peer review and claims payments on behalf of the insurer and states that it has no information sufficient to admit or deny this statement with respect to Pima Foundation.

65. Foundation members submit assigned claims for services, goods or products sold to Foundation policyholders directly to the Foundation.

Maricopa Foundation only admits that with respect to some health insurance plans endorsed by Maricopa Foundation, its participating and cooperating members may submit assigned claims for doctors services provided to patients insured under those plans to Maricopa Foundation and states it has no information sufficient to admit or deny the statement with respect to Pima Foundation.

66. Foundation members receive payment of assigned claims for services, goods or products sold to Foundation policyholders directly from the Foundation.

Maricopa Foundation only admits that with respect to some health insurance plans endorsed by Maricopa Foundation it writes drafts on the insurer's account as agent of the insurer to pay assigned claims from participating and cooperating members of Maricopa Foundation and states that it has no information sufficient to admit or deny the statement with respect to Pima Foundation.

67. Foundation members submit assigned claims for services, goods or products sold to Foundation policyholders on uniform claim forms provided by the Foundation.

Maricopa Foundation only admits its members are assigned payments on some Maricopa Foundation-endorsed health insurance policies and that it has supplied to members a preferred claim form for their use and states that it is without knowledge sufficient to admit or deny the statements made with respect to Pima Foundation.

68. The Maricopa Foundation and Pima Foundation use the same uniform claim form.

Denied.

69. The uniform claim form used by the Foundation calls for the doctor's usual fee for the service(s), good(s) or product(s) sold to Foundation policyholders.

Maricopa Foundation only admits that the claim forms approved for use by its participating and cooperating members have spaces for setting forth the usual and customary fee they have billed to the patient and states that it is without knowledge sufficient to admit or deny the statement made with respect to Pima Foundation.

70. Foundation members review claims submitted under Foundation Plans to determine the necessity of doctors' services to Foundation policyholders.

The Maricopa Foundation only admits that its peer review function is performed with respect to claims submitted by doctors to Maricopa Foundation for reimbursement for services performed by them on Foundation insured patients to determine if those services were medically necessary or appropriate and states that it is without sufficient knowledge to admit or deny with respect to Pima Foundation.

71. Foundation members review claims submitted under Foundation Plans to determine the payment(s) allowed for doctors' services to Foundation policyholders.

Maricopa Foundation only admits that its members review claims submitted for services performed on patients insured under Foundation plans to determine if those services were medically necessary or appropriate and if they were adequately described in the claim and states it is without knowledge sufficient to admit or deny the statement with respect to Pima Foundation.

72. Approximately five per cent of Foundation members charge less than the maximum fee allowed for their services to Foundation policyholders.

Maricopa Foundation only admits that, depending upon the medical procedure, between approximately five and fifteen percent of its members bill patients less than the maximum reimbursable levels of compensation for medical

services provided to patients insured under Maricopa Foundation-endorsed health insurance plans and states it has no information sufficient to admit or deny this statement with respect to Pima Foundation.

73. Criteria for the review of doctors' services to Foundation policyholders have been prepared by doctors who specialize in those services.

Denied as to Maricopa Foundation. Maricopa Foundation states it has no information sufficient to admit or deny this statement with respect to Pima Foundation.

74. The Foundation charges the insurers that underwrite Foundation Plans a service fee for the review and processing of claims.

The Maricopa Foundation only admits that it charges insurers that underwrite Maricopa Foundation-endorsed health insurance plans a fee when it provides peer review and claims processing service for the insurer and states that it has no information sufficient to admit or deny this statement with respect to Pima Foundation.

75. The Maricopa Foundation and the Pima Foundation have cooperated in the review and processing of claims on certain Foundation Plans, including the State of Arizona Plan.

Maricopa Foundation only admits that with respect to some health insurance plans endorsed by it, Pima Foundation was engaged by Maricopa Foundation to perform peer review and claims processing service as an agent of Maricopa Foundation for the insurer with respect to claims submitted for services performed by doctors in Pima County.

76. In August, 1975, the Maricopa Foundation was paying the salary of at least one employee of the Pima Foundation.

Maricopa Foundation only admits that for a time including August 1975 Maricopa Foundation paid to Pima Foundation the salary of at least one Pima Foundation employee engaged in the activities described in response to statement 75.

77. You do not underwrite the actuarial risk of Foundation Plans.

The Maricopa Foundation only admits this statement to the extent that it applies to the Maricopa Foundation and states it is without information sufficient to admit or deny this statement with respect to Pima Foundation.

78. You do not indemnify Foundation policyholders for the cost of services covered by Foundation Plans.

Maricopa Foundation only admits that its cooperating and participating members agree to accept as payment in full of their bills to patients insured under Maricopa Foundation-endorsed medical health insurance plans the maximum reimbursable levels of compensation for medical services provided to those patients if those maximum reimbursable levels of compensation are less than their bills and states that doctors who are not cooperating or participating members are not so bound and that it is without information sufficient to admit or deny this statement with respect to Pima Foundation.

79. You have not applied to the Director of Insurance of the State of Arizona for a certificate of authority to transact insurance in the State of Arizona pursuant to A.R.S. Section 20-216.

The Maricopa Foundation admits this statement.

80. You have not been issued a certificate of authority to transact insurance in the State of Arizona pursuant to A.R.S. Section 20-216.

The Maricopa Foundation admits this statement.

81. You have not applied to the Director of Insurance of the State of Arizona for a license to act as an agent, general agent, broker or solicitor pursuant to A.R.S. Section 20-287, 20-290, 20-291 or 20-295.

The Maricopa Foundation admits this statement.

82. You have not been issued a license to act as an agent, general agent, broker or solicitor pursuant to A.R.S. Section 20-287, 20-290, 20-291 or 20-295.

The Maricopa Foundation admits this statement.

83. You have not applied to the Director of Insurance of the State of Arizona for a certificate of registration as an insurance administrator pursuant to A.R.S. Section 20-485.12.

Denied.

84. You have not been issued a certificate of registration as an insurance administrator pursuant to A.R.S. Section 20-485.12.

Denied.

85. You have not applied for a certificate of authority to establish or operate a health care services organization pursuant to A.R.S. Section 20-1051 or 20-1052.

The Maricopa Foundation admits this statement.

86. You have not been issued a certificate of authority to establish or operate a health care services organization pursuant to A.R.S. Section 20-1051 or 20-1052.

The Maricopa Foundation admits this statement.

87. The Foundation is a member of the American Association of Foundations for Medical Care.

The Maricopa Foundation admits this statement only to the extent that it applies to the Maricopa Foundation and states it is without sufficient information to admit or deny this statement with respect to Pima Foundation.

88. The Foundation is a member of the American Association of Foundations for Professional Standards Review Organizations.

The Maricopa Foundation denies this statement only to the extent that it applies to the Maricopa Foundation and states it is without sufficient information to admit or deny this statement with respect to Pima Foundation.

* * * *

STATEMENTS TO BE ADMITTED BY DEFENDANTS MARICOPA SOCIETY AND MARICOPA FOUNDATION

90. The Foundation was founded in or about 1969.

Admitted.

91. The Foundation was founded to promote the practice of medicine on a fee for service basis is the State of Arizona.

The Maricopa Foundation only admits that the Maricopa Foundation was founded, *inter alia* to promote the practice of medicine in Maricopa County on a fee for service basis.

92. Between January, 1970 and April, 1970, the Foundation consulted with various groups of doctors with respect to the fees charged by their members for doctors' services.

See response to statement 44.

93. In or about 1970 the Foundation fee schedule included unit conversion factors of:

(a) 7.50 for medicine;
(b) 6.50 for surgery;
(c) 5.00 for laboratory;
(d) 7.50 for anesthesiology.

Maricopa Foundation only admits that the conversion factors used by Maricopa Foundation to calculate maximum reimbursable levels of compensation payable by the insurer to doctors for services provided to patients insured under Maricopa Foundation-endorsed health insurance plans are as stated in statement 93.

94. In or about 1972 the Foundation fee schedule included unit conversion factors of:

(a) 8 for medicine;
(b) 7 for surgery;
(c) 5.50 for laboratory;
(d) 7 for radiology with a professional component of $1.70;
(e) 8 for anesthesiology.

Maricopa Foundation only admits that the conversion factors used by Maricopa Foundation to calculate maximum reimbursable levels of compensation payable by the insurer to doctors for services provided to patients insured under Maricopa Foundation-endorsed health insurance plans are as stated in statement 94.

95. The Foundation fee schedule adopted in or about January, 1974 included unit conversion factors of:

(a) 8.60 for medicine;
(b) 7.50 for surgery;
(c) 5.90 for laboratory;
(d) 7.50 for radiology with a professional component of $1.70;
(e) 8.60 for anesthesiology.

The Maricopa Foundation admits that the following conversion factors were in effect as of January 1, 1974 with respect to Maricopa Foundation-endorsed plans having an effective date on or after January 1, 1974 for use in calculating maximum reimbursable levels of compensation payable by the insurer to doctors for services provided to patients insured under such plans:

(a) $8.60 for medicine, pathology (procedures 8901 through 8925) and anesthesiology (with one risk modifier in anesthesia allowed for emergency cases after 6:00 p.m.);

(b) $7.50 for surgery and radiology (with a professional component of $1.70); and

(c) $5.90 for clinical laboratory.

96. The Foundation fee schedule adopted in or about November, 1974 included unit conversion factors of:

(a) 10 for medicine;
(b) 8.50 for surgery;
(c) 6.50 for laboratory;
(d) 7.50 for radiology with a professional component of $1.70;
(e) 10 for anesthesiology.

The Maricopa Foundation admits that the following conversion factors were in effect as of November 1, 1974 with respect to Maricopa Foundation-endorsed plans having an effective date on or after November 1, 1974 for use in calculating maximum reimbursable levels of compensation payable by the insurer to doctors for services provided to patients insured under such plans:

(a) $10.00 for medicine, pathology (procedures 8901 through 8925) and anesthesiology (with one risk modifier in anesthesia allowed for emergency cases after 6:00 p.m.);

(b) $8.50 for surgery;

(c) $7.50 for radiology with a professional component of $1.70, and;

(d) $6.50 for clinical pathology.

97. Between 1970 and November, 1974, the Foundation fee schedule for medicine increased approximately 33.3 per cent.

Maricopa Foundation only admits that between 1970 and November 1974 its conversion factor applicable to determine the maximum reimbursable levels of compensation payable by insurers to doctors for medical services provided to patients insured under Maricopa Foundation-endorsed plans increased approximately 33.3%.

98. Between 1970 and November, 1974, the Foundation fee schedule for anesthesia increased approximately 31 per cent.

The Maricopa Foundation only admits that its conversion factor applicable to determination of the maximum reimbursable levels of compensation payable by insurers to doctors for anesthesia increased approximately 33% during the period 1970 to November 1974.

99. Between 1970 and November, 1974, the Foundation fee schedule for surgery increased approximately 31 per cent.

The Maricopa Foundation only admits that between 1970 and November 1974 its conversion factor applicable to determine the maximum reimbursable levels of compensation payable by insurers to doctors for surgical services provided to patients insured under Maricopa Foundation-endorsed plans increased approximately 31%.

100. Between 1970 and November, 1974, the Foundation fee schedule for pathology increased approximately 30 per cent.

The Maricopa Foundation only admits that between 1970 and November 1974 its conversion factor applicable to determine the maximum reimbursable levels of compensation payable by insurers to doctors for pathological services provided to patients insured under Maricopa Foundation-endorsed plans increased approximately 31%.

101. *Round-Up* is a regular publication of the Society.

The Maricopa Foundation has no information sufficient to admit or deny the truth or falsity of this statement and refers to the response provided by the Maricopa Society for Medical Care.

102. *Round-Up* is published, circulated or distributed to the Society's members.

The Maricopa Foundation has no information sufficient to admit or deny the truth or falsity of this statement and refers plaintiff to the response provided by the Maricopa Society for Medical Care.

103. In or about January, 1973, the Foundation fee schedule was published in *Round-Up*.

The Maricopa Foundation has no information sufficient to admit or deny the truth or falsity of this statement and refers plaintiff to the response provided by the Maricopa Society for Medical Care.

104. In or about March, 1973, the Foundation's Minimum Standards Committee consulted with the Arizona Society of Internal Medicine on criteria for coverage of annual physical examinations.

Maricopa Foundation only admits that in or about March 1973, Maricopa Foundation's Minimum Standards Committee consulted with the Arizona Society of Internal Medicine on criteria for health insurance coverage of annual physical examinations.

105. In or about March, 1973, the Foundation's Minimum Standards Committee consulted with the Phoenix Psychiatric Council on criteria for coverage of psychological services.

Maricopa Foundation only admits that in or about March 1973, Maricopa Foundation's Minimum Standards Committee consulted with the Phoenix Psychiatric Council on criteria for health insurance coverage of psychological services.

106. In or about March, 1973, the Foundation's Minimum Standards Committee consulted with the Arizona Chapter of the American Academy of Orthopedic Surgeons on criteria for coverage of doctors' services rendered by orthopedic assistants.

Maricopa Foundation only admits that in or about March 1973, Maricopa Foundation's Minimum Standards Committee consulted with the Arizona Chapter of the American Academy of Orthopedic Surgeons on criteria for health insurance coverage of doctors' services rendered by orthopedic assistants.

107. In or about March, 1973, the Foundation's Minimum Standards Committee consulted with the Phoenix Pediatric Society on criteria for coverage of well baby care.

Maricopa Foundation only admits that in or about March 1973, Maricopa Foundation's Minimum Standards Committee consulted with the Phoenix Pediatric Society on criteria for health insurance coverage of well baby care.

108. In or about March 20, 1973, the Foundation's Board of Trustees reviewed the work of the Foundation's Minimum Standards Committee.

The Maricopa Foundation only admits that on or about March 30, 1973 its Board of trustees reviewed the March 6, 1973 minutes of the Maricopa Foundation's Minimum Standards Committee.

109. On or about March 20, 1973, the Foundation's Board of Trustees directed the Chariman of the Foundation's Minimum Standards Committee to obtain the recommendation of the Phoenix OB-GYN Society on coding for obstetrical and gynecological services.

The Maricopa Foundation only admits that on or about March 20, 1973, Dr. Pent, a Maricopa Foundation board member, agreed to follow-up on the Maricopa Foundation's request to the Phoenix OB-GYN Society for its recommendation concerning the coding of cesarian sections for use in health insurance coverage.

110. In or about April, 1973, the Foundation's Minimum Standards Committee sent the report of its sub-committee on well baby care to the Phoenix Pediatric Society.

The Maricopa Foundation only admits that the April 10, 1973 minutes of its Minimum Standards Committee state that a copy of the report of its subcommittee on well baby care would be sent to the Arizona Pediatric Society.

111. In or about April, 1973, the Foundation's Minimum Standards Committee sent the report of its sub-committee on well baby care to the Phoenix Chapter American Academy of Family Practice.

The Maricopa Foundation only admits that the April 10, 1973 minutes of its Minimum Standards Committee state that a copy of the report of its subcommittee on well baby care would be sent to the American Academy of family Practice.

112. In or about April, 1973, the Foundation's Minimum Standards Committee requested the advice of the Phoenix Psychiatric Council on coverage for psychological services.

The Maricopa Foundation only admits that the April 10, 1973 minutes of its Minimum Standards Committee state that the committee should meet with members of the Phoenix Psychiatric Society and members of the local psychological association for their recommendations with respect to inclusion in the minimum standards for health insurance plans of payment for psychological testing.

113. In or about April, 1973, the Foundation's Minimum Standards Committee requested the advice of the an orthopedic society on appropriate coverage of services performed by orthopedic surgeons.

The Maricopa Foundation only admits that the April 10, 1973 minutes of its Minimum Standards Committee state that the Orthopedic Society would be asked to make a recommendation with respect to the utilization of orthopedic services covered under Maricopa Foundation-endorsed health insurance plans.

114. In or about April, 1973, the Foundation's Board of Trustees decided not to establish a fee schedule for obstetrical and gynecological services without the advice of the Phoenix OB-GYN Society.

The Maricopa Foundation only admits that on or about April 1973 its Board of Trustees decided not to alter the use of the 1964 California Relative Value Schedule with respect to determining maximum reimbursement levels for obstetrical services under Foundation-endorsed health insurance plans and that it would make no changes to maximum levels of reimbursement under Maricopa Foundation-endorsed health insurance plans with respect to such services prior to obtaining information from the Phoenix OB-GYN Society.

115. In or about April, 1973, the Foundation's Board of Trustees agreed to increase the Foundation's allowed fees for obstetrical and gynecological services in accordance with the suggestions of the Phoenix OB-GYN Society.

Denied. See pages 2 and 3 of the Minutes of the Maricopa Foundation's Board of Trustees dated April 17, 1973.

116. On or about April 11, 1973, a representative of the Foundation's Minimum Standards Committee informed members of the Phoenix Psychiatric Council of a fee schedule for emergency services.

The Maricopa Foundation has no information sufficient to admit or deny the truth or falsity of this statement.

117. In or about May, 1973, increases in the unit values used by the Foundation for some doctors' services were published in *Round-Up*.

The Maricopa Foundation has no information sufficient to admit or deny the truth or falsity of this statement and refers plaintiff to the response provided by the Maricopa Society for Medical Care.

118. On or about May 16, 1973, representative(s) of the Foundation's Minimum Standards Committee asked the Phoenix Psychiatric council for information on the prices of various psychiatric services.

The Maricopa Foundation has no information sufficient to admit or deny the truth or falsity of this statement.

119. On or about September 18, 1973, the Foundation's Board of Trustees decided to poll Foundation members with respect to possible increases in the Foundation fee schedule.

Maricopa Foundation only admits that on or about September 18, 1973 the Maricopa Foundation's Board of Trustees decided to poll Foundation cooperating and participating members with respect to a proposed increase in Maricopa Foundation's maximum reimbursable payment for medical services rendered to patients insured under Maricopa Foundation-endorsed plans.

120. On or about September 18, 1973, the Foundation's Board of Trustees recommended that Foundation members approve a 7.5 percent increase in the Foundation fee schedule.

Maricopa Foundation only admits that on or about September 18, 1973, the Maricopa Foundation's Board of Trustees recommended that Foundation members approve a 7.5% increase in Maricopa Foundation's maximum reimbursable payment for medical services rendered to patients insured under Maricopa Foundation-endorsed plans.

121. Prior to September 18, 1973, the Internal Revenue Service indicated it would allow a maximum 7.5 percent increase in the Foundation fee schedule.

Maricopa Foundation only admits that prior to September 18, 1973 it was informed by the United States Government that a 7.5% increase in maximum reimbursable payments for medical services rendered to patients insured under Maricopa Foundation-endorsed plans was the maximum allowed under the federal government's wage and price controls then in effect.

122. On or about November 1, 1973, representative(s) of the Foundation's Fee Schedule Committee met with representatives of the Phoenix Surgical Society regarding possible increases in the unit values used by the Foundation for certain surgical services.

Maricopa Foundation only admits that on or about November 1, 1973 representatives of Maricopa Foundation's Fee Schedule Committee met with representatives of the Phoenix Surgical Society concerning possible increases in unit values used by Maricopa Foundation to determine maximum reimbursable payment for medical services rendered to patients insured under Maricopa Foundation-endorsed health insurance plans.

123. On or about November 14, 1973, a representative of the Phoenix OB-GYN Society informed a representative of the Foundation's Fee Schedule Committee of the results of

a fee survey conducted by the Phoenix OB-GYN Society on the fees its members charged for certain obstetrical and gynecological services.

Admit.

124. On or about November 14, 1973, representatives of the Phoenix OB-GYN Society conveyed to representatives of the Foundation's Fee Schedule Committee proposed increases in the fees allowed by the Foundation for certain obstetrical and gynecological services.

Admit only that on or about November 15, 1973 representatives of the Phoenix OB-GYN Society conveyed to representatives of the Foundation's Fee Schedule Committee proposed increases in the maximum reimbursable payment for certain obstetrical and gynecological services rendered to patients insured under Maricopa Foundation-endorsed health insurance plans.

125. On or about November 14, 1973, representatives of the Phoenix OB-GYN Society conveyed to representatives of the Foundation's Fee Schedule Committee the Phoenix OB-GYN Society's support for proposed increases in the fees allowed by the Foundation for certain obstetrical and gynecological services.

Admit only that on or about November 14, 1973 representatives of the Phoenix OB-GYN Society conveyed to representatives of the Foundation's Fee Schedule Committee proposed increases in the maximum reimbursable payment for certain obstetrical and gynecological services rendered to patients insured under Maricopa Foundation-endorsed health insurance plans.

126. On or about November 14, 1973, representative(s) of the Foundation's Fee Schedule Committee met with representatives of any orthopedic society regarding the use of the 1969 edition of the California Relative Value Schedule for certain surgical services.

Admit only that on or about November 14, 1973 representatives of the Maricopa Foundation's Fee Schedule Committee met with representatives of an orthopedic society concerning use of the 1969 edition of the California Relative Value Schedule to determine maximum reimbursable payment for certain surgical services rendered to patients insured under Maricopa Foundation-endorsed health insurance plans.

127. On or about November 20, 1973, the Chairmen of the Foundation's Fee Schedule Committee reported to the Foundation's Board of Trustees on a meeting of said Chairmen with representatives of an orthopedic society.

Admit.

128. On or about November 20, 1973, the Chairmen of the Foundation's Fee Schedule Committee reported to the Foundation's Board of Trustees on a meeting of said Chairmen with representatives of the Arizona Society of Internal Medicine.

Admit.

129. On or about November 20, 1973, the Chairmen of the Foundation's Fee Schedule Committee recommended to the Foundation's Board of Trustees certain changes in the unit values used by the Foundation for certain surgical, obstetrical and gynecological procedures.

Admit only that on or about November 20, 1973 the Chairman of the Maricopa Foundation's Fee Schedule Committee recommended to the Foundation's Board of Trustees various changes in unit values used by the Maricopa Foundation to determine maximum reimbursable payment for certain surgical, obstetrical and gynecological services rendered to patients insured under Maricopa Foundation-endorsed health insurance plans.

130. On or about November 20, 1973, the Chairmen of the Foundation's Fee Schedule Committee recommended to the Foundation's Board of Trustees that the Foundation poll various groups of doctors with respect to the Foundation fee schedule.

Admit only that on or about November 20, 1973 the Chairman of the Maricopa Foundation's Fee Schedule Committee recommended to the Foundation's Board of Trustees that the Maricopa Foundation survey various professional organizations with respect to the maximum reimbursable payment for medical services rendered to patients insured under Maricopa Foundation-endorsed health insurance plans.

131. On or about November 20, 1973, the Chairmen of the Foundation's Fee Schedule Committee informed the Foundation's Board of Trustees that they planned to continue meeting with groups of doctors concerning the unit values which the Foundation used for or accorded to the services in which those respective groups of doctors specialized.

Denied. See Minutes of the Maricopa Foundation Board of Trustees dated November 20, 1973.

132. Prior to December, 1973, the Phoenix Pediatric Society requested the revision of the Foundation's minimum standards to require coverage of well baby care.

The Maricopa Foundation only admits that sometime after April 10, 1973 its subcommittee on well baby care submitted its report with respect to the inclusion of well-baby coverage in the Maricopa Foundation's minimum standards to the Arizona Pediatric Society for its comments, that on or about December 18, 1973 the Maricopa Foundation's Minimum Standards Committee recommended and its Board of Trustees approved the inclusion of well baby care in the Maricopa Foundation's minimum

standards, that on or about January 15, 1974 the Maricopa Foundation's Board of Trustees reversed its decision and well baby care has at all times not been required by the Maricopa Foundation's minimum standards.

133. On or about December 18, 1973, the Foundation's Board of Trustees approved revision of the Foundation's minimum standards to require coverage of doctors' services for well baby care under Foundation Plans.

Maricopa Foundation repeats its response to statement 132.

134. Prior to December 18, 1973, an orthopedic society recommended to the Foundation that the services of orthopedic assistants who were not doctors should not be covered under Foundation Plans.

The Maricopa Foundation only admits that the American Academy of Orthopedic Surgeons and the Central Orthopedic Association of Arizona provided information to the Foundation's Minimum Standards Committee used by it in making its recommendations that charges for the services of orthopedic assistants who were not doctors should not be required to be reimbursed under Foundation-endorsed medical health insurance plans.

135. On or about December 18, 1973, the Foundation's Board of Trustees decided not to revise the Foundation's minimum standards to require coverage of the services of orthopedic assistants who were not doctors.

The Maricopa Foundation only admits that on or about December 18, 1973 its Board of Trustees decided not to revise the Foundation's minimum standards to require that services of orthopedic assistants who were not doctors should be required to be reimbursed under Foundation-endorsed medical health insurance plans.

136. On or about January 1, 1974, the Foundation increased the unit values and the conversion factors used by the Foundation for certain obstetrical and gynecological services.

The Maricopa Foundation only admits that on or about December 18, 1973 its Board of Trustees approved increases in unit values for certain obstetrical and gynecological procedures to be effective January 1, 1974 and that increases in conversion factors effective January 1, 1974 were applicable to those procedures and that those unit values and conversion factors were for use in determining maximum reimbursable payment for those procedures performed on patients insured under Maricopa Foundation-endorsed health insurance plans.

137. The Phoenix OB-GYN Society had recommended the increases adopted by the Foundation in January, 1974 in the unit values and conversion factors used by the Foundation for certain obstetrical and gynecological services.

Maricopa Foundation only admits that the recommendations of the Phoenix OB-GYN Society to Maricopa Foundation for increases in unit values and conversion factors used by the Foundation to determine maximum reimbursable payment for certain obstetrical and gynecological services performed for patients insured under Maricopa Foundation-endorsed health insurance plans were the same as the increases approved by the Foundation.

138. On or about January 1, 1974, one risk modifier for anesthesia was added to the Foundation fee schedule.

Maricopa Foundation admits only that on or about January 1, 1974 one risk modifier for anesthesia was added in determining the maximum reimbursable payment for anesthesiological services performed for patients insured under Maricopa Foundation-endorsed health insurance plans.

139. On or about January 1, 1974, the Foundation increased the unit values used by the Foundation for various surgical services.

Maricopa Foundation only admits that on or about January 1, 1974 the Foundation increased the unit values used by it to determine the maximum reimbursable payment for certain surgical services performed on patients insured under Maricopa Foundation-endorsed health insurance plans.

140. On or about January 1, 1974, the Foundation increased the conversion factor used by the Foundation for surgery.

Maricopa Foundation only admits that on or about January 1, 1974 the conversion factor used by it to determine the maximum reimbursable payment for surgical services performed on patients insured under Maricopa Foundation-endorsed health insurance plans effective on or after January 1, 1974 was increased.

141. On or about January 1, 1974, the Foundation's fee schedule was increased by approximately 7.5 percent.

Maricopa Foundation only admits that the conversion factors adopted by it for use to determine maximum reimbursable payment for medical services performed on patients insured under Maricopa Foundation-endorsed health insurance plans were increased approximately 7.5% with respect to such plans effective on or after January 1, 1974.

142. In January 1974, the Motorola Corporation conveyed to the Foundation statistics showing that doctors' fees incurred by Motorola employees in the Phoenix area were significantly higher than doctors' fees incurred by Motorola employees in the Chicago area.

The Maricopa Foundation only admits that on or about February 28, 1973 Motorola, Inc. transmitted statistics comparing health care costs in Phoenix and Chicago during 1971-72 which statistics were briefly discussed during the Board of Trustees meeting of the Maricopa Foundation on or about January 15, 1974.

143. On or about November 30, 1973, the Foundation asked an insurance consultant to estimate the increases in premiums on Foundation Plans that would be caused by the increases in the Foundation fee schedule effective January 1, 1974.

Maricopa Foundation only admits that on or about November 30, 1973 the Foundation asked an insurance consultant to provide actuarial assistance in estimating increases in premiums on Foundation-endorsed health insurance plans likely to occur as a result of increases in the maximum reimbursable payment for medical services performed on patients insured under Maricopa Foundation-endorsed health insurance plans proposed to become effective with respect to such plans on or after January 1, 1974.

144. In or about January, 1974, Cal Western realized an incurred loss in excess of $47,000 on the Maricopa Society's group insurance trust for 1973.

Maricopa Foundation only admits that for the twelve month period ending January 31, 1974, Cal Western Life estimated an incurred loss with respect to the Maricopa County Medical Society Group Insurance Trust of $47,166.00.

145. By January, 1974, Cal Western's incurred loss on the Maricopa Society group insurance trust totalled over $79,000.

Admitted.

146. On or about January 8, 1974, the Society's Board of Directors approved a 10 percent increase in premiums on the Society's own group insurance trust.

The Maricopa Foundation has no information sufficient to admit or deny the truth or falsity of this statement and refers plaintiff to the response provided by the Maricopa Society for Medical Care.

147. The 10 percent premium increase approved in January, 1974 on the Society's group insurance trust was necessary to cover increases in the Foundations fee schedule and the additional coverage of obstetrical and well baby care.

The Maricopa Foundation has no information sufficient to admit or deny the truth or falsity of this statement and refers plaintiff to the response provided by the Maricopa Society for Medical Care.

148. In or about January, 1974, the Foundation formed an Insurance Advisory Committee.

Admitted.

149. After Federal Wage and Price Controls were lifted in 1974, the Foundation took steps to increase the Foundation fee schedule to a level approximating the usual or customary fees for doctors' services in Maricopa County.

Denied.

150. On or about June 11, 1974, the Foundation sent a uniform health insurance claim form endorsed by the Arizona Medical Association to doctors in Maricopa County, Arizona.

Admitted.

151. On or about June 14, 1974, the Foundation's Executive Director made a written report to the Foundation's Executive Committee on the operations and philosophy of the Foundation.

Admit only that on or about June 14, 1974, the Maricopa Foundation's Executive Director made a written report to the Foundation's Executive Committee and refer to that report for its contents.

152. On or about June 17, 1974, the Foundation's Board of Trustees decided to prepare a new Foundation fee schedule which would increase the fees allowed for doctors' services to Foundation policyholders.

The Maricopa Foundation only admits that on or about June 17, 1974, its Board of Trustees discussed the possibility of increasing the conversion factors then in effect with respect to determining maximum reimbursable levels for medical services provided to patients insured under Maricopa Foundation-endorsed health insurance plans.

153. On or about June 14, 1974, the Foundation's Board of Trustees decided to poll Foundation members on the relative value schedules and conversion factors they were using.

The Maricopa Foundation only admits that on or about June 17, 1974, its Board of Trustees decided to survey the Maricopa Foundation membership with respect to the fees charged by them, as expressed by a relative value schedule and conversion factor in order to obtain an overall view of the current trends in medical charges in the community.

154. Beginning on or about June 20, 1974, the Foundation polled Foundation members to determine the fees they were charging for their services.

Admit.

155. On or about June 27, 1974, the Foundation informed the members of the Foundation's Insurance Advisory Committee of the Foundation's expectation that the Foundation fee schedule would be increased.

The Maricopa Foundation only admits that on or about June 27, 1974 the Insurance Advisory Committee discussed a possible increase in the conversion factors used by Maricopa Foundation to determine maximum reimbursable levels for medical services provided to patients insured under Maricopa Foundation-endorsed health insurance plans.

156. On or about July 5, 1974, the Foundation sent Foundation members a ballot for approval of an increased Foundation fee schedule.

The Maricopa Foundation only admits that on or about July 5, 1974 the Maricopa Foundation sent its members ballots through which they could approve or disapprove proposed conversion factors to be used in connection with determining the maximum level of reimbursement payable to physicians for services rendered to patients insured under Maricopa Foundation-endorsed health insurance plans.

157. On or about July 5, 1974, the Foundation informed its members that the Foundation was seeking to make its fee schedule consistent with the usual and customary fee for doctors' services in the community.

Admit only that on or about July 5, 1974 the Maricopa Foundation wrote to its members that one of its goals was to make the maximum reimbursable levels for medical services provided to patients insured under Maricopa Foundation-endorsed health insurance plans consistent with usual and customary fees for doctors services in the community.

158. By July 15, 1974, Foundation members had approved the proposed increases in the Foundation fee schedule by a vote of approximately 291 to 19.

Admit only that by July 15, 1974 Maricopa Foundation members had voted to approve an increase in maximum reimbursable levels for medical services provided to patients insured under Maricopa Foundation-endorsed health insurance plans by a margin of approximately 291 to 19.

159. On or about July 15, 1974, the Foundation's Board of Trustees discussed the Foundation's use of the relative value schedule prepared by the American College of Radiology in lieu of the 1964 California Relative Value Schedule for Radiology.

The Maricopa Foundation only admits that on or about July 15, 1974 its Board of Trustees discussed the possibility of incorporating in lieu of the 1964 California Relative Value Schedule the relative value schedule prepared by the American College of Radiology into its minimum standards with respect to maximum reimbursable levels for radiological procedures provided by physicians to patients insured under Maricopa Foundation-endorsed health insurance plans.

160. On or about July 15, 1974, the Foundation's Board of Trustees considered establishing a conversion factor of 7 for radiology, but decided to poll the radiologists in the community to see if that was sufficient.

The Maricopa Foundation only admits that on or about July 15, 1974 its Board of Trustees considered using a conversion factor of 7.0 in conjunction with the American College of Radiology relative value schedule to determine maximum reimbursable levels for radiological procedures, but decided to survey local radiologists to determine whether that conversion factor would result in maximum reimbursement levels for radiological services supplied to patients insured under Maricopa Foundation-endorsed health insurance plans comparable to fees currently charged in the community.

161. On or about July 15, 1974, representatives of the Arizona Psychiatric Society complained to the Foundation's Board of Trustees that the coverage of psychiatric services required by the Foundation's minimum standards was inadequate.

The Maricopa Foundation only admits that on or about July 15, 1974 its Board of Trustees received a complaint from the president of the Arizona Psychiatric Society that the Maricopa Foundation maximum reimbursable level of $10.00 per visit for patients insured under Maricopa Foundation-endorsed health insurance plans was unsatisfactory.

162. On or about July 15, 1974, Patrick Moraca reported to the Foundation's Board of Trustees on his meeting with representatives of the Arizona Chapter of the American Academy of Family Practice.

Admit.

163. On or about July 29, 1974, the Foundation informed insurers that were underwriting Foundation Plans of the increased Foundation fee schedule and revised Foundation minimum standares to be effective November 1, 1974.

Admit only that on or about July 29, 1974 the Maricopa Foundation informed insurers that were underwriting Maricopa Foundation-endorsed health insurance plans that effective November 1, 1974 the Maricopa Foundation's revised minimum standards would take effect and maximum reimbursable levels for medical services for patients insured under Maricopa Foundation-endorsed health insurance plans would increase.

164. By August 19, 1974, the Foundation members approved the recommended increases in the Foundation fee schedule by a vote of approximately 657 to 53.

Admit only that on or about August 19, 1974 the Maricopa Foundation members had voted to approve an increase in maximum reimbursable levels for medical services provided to patients insured under Maricopa Foundation-endorsed health insurance plans by a margin of approximately 657 to 53.

165. On or about August 19, 1974, the Foundation's Board of Trustees appointed a committee to study possible coverage of the services of surgical assistants who were not doctors.

Admit only that on or about August 19, 1974, the Maricopa Foundation's Board of Trustees appointed a committee to study possible medical insurance coverage of the services of surgical assistants who were not doctors under Maricopa Foundation-endorsed health insurance plans.

166. On or about August 19, 1974, the Foundation's Board of Trustees directed the Chairman of the Foundation's committee to study possible coverage of the services of non-doctor surgical assistants to obtain the opinion of the Phoenix Surgical Society on such coverage.

The Maricopa Foundation admits only that on or about August 19, 1974 its Board of Trustees decided to send a letter to the Phoenix Surgical Society asking that group's opinion and recommendation with respect to health insurance coverage under Maricopa Foundation-endorsed health insurance plans of services provided by surgical assistants.

167. On September 10, 1974, the Foundation asked the opinion of the Phoenix Surgical Society on coverage for services provided by surgical assistants who were not doctors.

The Maricopa Foundation admits only that on or about September 10, 1974, it asked the Phoenix Surgical Society to review the concept of the use of surgical assistants in order for the Maricopa Foundation to determine whether

coverage under Maricopa Foundation-endorsed health insurance plans of use of assistants would reduce the cost of medical care while at the same time provide quality and necessary medical care.

168. On or about October 11, 1974, the Foundation published, circulated or distributed a report on its five-year history which showed 30 per cent to 33.3 percent increases in the Foundation fee schedule between 1970 and November 1, 1974.

Admit only that on or about October 11, 1974, the Maricopa Foundation published, circulated or distributed a report on its five-year history and that report showed 30 to 33.3% increases in maximum levels of compensation payable by insurers to doctors for services provided to patients insured under Maricopa Foundation-endorsed health insurance plans between 1970 and November 1, 1974.

169. On or about October 11, 1974, the Foundation sent Foundation members a report showing 30 percent to 33.3 percent increases in the Foundation fee schedule between 1970 and November 1, 1974.

Admit only that on or about October 11, 1974, the Maricopa Foundation published, circulated or distributed a report on its five-year history and that report showed 30 to 33.3% increases in maximum levels of reimbursement payable by insurers to doctors for services provided to patients insured under Maricopa Foundation-endorsed health insurance plans between 1970 and November 1, 1974.

170. On or about October 16, 1974, the Executive Director of the Foundation sent the Foundation's minimum standards on well baby care to a representative of the Pima Foundation.

Admitted.

171. On or about October 16, 1974, the Foundation's Executive Director sent the Foundation fee schedule effective November 1, 1974 to a representative of the Pima Foundation.

The Maricopa Foundation only admits that on or about October 16, 1974 the Foundation's Executive Director sent the conversion factors used by it to determine maximum levels of reimbursement payable by insurers to doctors for services provided to patients insured under Maricopa Foundation-endorsed health insurance plans to a representative of the Pima Foundation.

172. In or about November, 1974, an article which reported a 33 percent increase in Foundation fee schedules since 1970 was published in *Round-Up*.

The Maricopa Foundation has no information sufficient to admit or deny the truth or falsity of this statement and refers plaintiff to the response provided by the Maricopa Society.

173. In or about November, 1974, the Foundation fee schedule effective November 1, 1974 was published in *Round-Up*.

The Maricopa Foundation has no information sufficient to admit or deny the truth or falsity of this statement and refers plaintiff to the response provided by the Maricopa Society.

174. In or about November, 1974, the Foundation fee schedule effective November 1, 1974 was provided to the Occupational Health Committee of the Arizona Medical Association.

The Maricopa Foundation has no information sufficient to admit or deny the truth or falsity of this statement and refers plaintiff to the response provided by the Maricopa Society.

175. In or about November or December, 1974, the Foundation told Dr. Glenn Friedman that his proposal for a pediatric early discharge program to curb medical costs should be presented to the pediatric society before being presented for approval to the Foundation's Board of Trustees.

The Maricopa Foundation only admits that on or about December 20, 1974, its president asked Dr. Glenn Friedman to discuss his suggested programs for early hospital discharge for new borns and other pediatric patients to curb medical costs with the Pediatric Society.

176. On or about November 12, 1974, the Foundation sent its five-year report showing 30 to 33.3 percent increases in Foundation fee schedules between 1970 and November 1, 1974 to non-member doctors with applications for membership in the Foundation.

Admit only that on or about November 12, 1974 the Maricopa Foundation sent a report on its five-year history to non-member doctors with applications for membership in the Maricopa Foundation and that report showed 30 to 33.3% increases in maximum levels of reimbursement payable by insurers to doctors for services provided to patients insured under Maricopa Foundation-endorsed health insurance plans between 1970 and November 1, 1974.

177. On or about December 10, 1974, the Society's Board of Directors elected six new trustees to the Foundation's Board of Trustees.

The Maricopa Foundation only admits that in December 1974 the administrative members of the Maricopa Foundation re-elected two persons to the Board of Trustees and elected five additional persons to the Foundation's Board of Trustees.

178. On or about December 12, 1974, the Foundation held meetings for doctors in Scottsdale, Mesa, Tempe and Chandler at which members of the Foundation's Board of Trustees discussed Foundation activities with those who attended.

Admit.

179. On or about December 16, 1974, representatives of the Phoenix Psychiatric Council presented to the Foundation's Board of Trustees the Council's recommendation for required coverage for outpatient psychiatric care under Foundation Plans.

The Maricopa Foundation only admits that on or about December 16, 1974 representatives of the Psychiatric Council presented recommendations to the Maricopa Foundation's Board of Trustees for inclusion of outpatient psychiatric coverage in the Maricopa Foundation's minimum standards for endorsed health insurance plans.

180. On or about December 16, 1974, the Foundation's Board of Trustees asked representatives of the Phoenix Psychiatric Council to help the Foundation prepare criteria for coverage of outpatient psychiatric care under Foundation Plans.

The Maricopa Foundation only admits that on or about December 16, 1974 its Board of Trustees decided to ask the Psychiatric Council for assistance in formulating peer review guidelines for both inpatient and outpatient review of claims under Maricopa Foundation-endorsed health insurance plans.

181. On or about January 23, 1975, the Foundation asked the Phoenix OB-GYN Society to decide whether a surgical assistant was necessary for certain obstetrical and gynecological procedures.

The Maricopa Foundation only admits that on or about January 23, 1975, it asked the Phoenix OB-GYN Society for its opinion whether a surgical assistant is medically necessary for the performance of vaginal tubal ligations for the

purpose of determining whether Maricopa Foundation-endorsed health insurance plans should provide reimbursement for such services.

182. In or about January, 1975, Foundation representative(s) met with representatives of the Phoenix Psychiatric Council.

The Maricopa Foundation only admits that in December 1974 representatives of the Phoenix Psychiatric Council met with the Maricopa Foundation's Board of Trustees. *See* letter of Patrick P. Moraca to Howard Gray, M.D. dated January 16, 1975.

183. In or about January, 1975, the Foundation agreed to endorse coverage of up to $800 for outpatient psychiatric care under Foundation Plans.

The Maricopa Foundation only admits that commencing November 1, 1974 it included within its minimum standards for Foundation-endorsed health insurance plans coverage for outpatient psychiatric services at the rate of 50% of the first $20.00 of insured charges per treatment with a maximum benefit of $750.00 per year.

184. In or about January, 1975, the Foundation decided not to include coverage of the cardiac conditioning program of the Arizona Heart Institute in its minimum standards for Foundation Plans.

Admit.

185. In or about January, 1975, the Foundation informed Greyhound Corporation of the Foundation's decision not to include coverage of the cardiac conditioning program of the Arizona Heart Institute in its minimum standards or Foundation Plans.

The Maricopa Foundation only admits that on or about January 24, 1975 it informed the Greyhound Corporation that its Board of Trustees had decided not to include the

cardiac conditioning program of Cardiovascular Diagnostic Laboratories Inc. within the minimum standards of the Maricopa Foundation for Maricopa Foundation-endorsed health insurance plans.

186. In or about January, 1975, the Foundation provided the Foundation fee schedule for 1975 to the Pima Foundation.

Admit only that on or about October 16, 1974 the Maricopa Foundation's Executive Director sent the conversion factors used by it to determine maximum levels of compensation payable by insurers to doctors for services provided to patients insured under Maricopa Foundation-endorsed health insurance plans to a representative of the Pima Foundation.

187. On or about February 1, 1975, Pacific Mutual Life Insurance Company replaced Cal Western as the underwriter for the society's group insurance trust.

Admit.

188. On or about February 1, 1975, Pacific Mutual Life Insurance Company increased the premium on the Society's group insurance trust by approximately 26 per cent over the 1974 premium.

Admit.

189. At a meeting of the Medical Economics Committee of the Arizona Medical Association on or about March 1, 1975, the Foundation's President discussed the Foundation's preparation of a relative value schedule for Arizona doctors.

The Maricopa Foundation is without information sufficient to admit or deny the truth or falsity of this statement.

190. On or about March 1, 1975, the Foundation's President told members of the Medical Economics Committee of the Arizona Medical Association that the relative value

schedule which the Foundation was preparing would incorporate features of the 1969 and 1974 editions of the California Relative Value Schedule and use a consistent point system in all sections.

The Maricopa Foundation is without information sufficient to admit or deny the truth or falsity of this statement.

191. On or about May 12, 1975, the Foundation's Executive Director conveyed to the Foundation's Fee Schedule Committee a doctor's comments on the Foundation's fee schedule for thoracic surgery.

The Maricopa Foundation only admits that on or about March 12, 1975 its Executive Director informed a physician that his letter dated March 6, 1975 with respect to maximum reimburseable allowances for services to patients insured under Maricopa Foundation-health insurance plans for certain procedures performed by thoracic surgeons had been referred to the Maricopa Foundation's fee schedule committee.

192. On or about May 12, 1975, the Foundation's Executive Director requested a report from the Foundation's Fee Schedule Committee on the comments of the "thoracic community" with respect to the Foundation's allowed fees for thoracic surgery.

The Maricopa Foundation only admits that on or about May 5, 1975, its President requested the Maricopa Foundation's fee schedule committee to pursue an adjustment to the California Relative Value Schedule with respect to tube thorastomy, if justified, and to investigate other possible discrepancies with respect to the Maricopa Foundation's maximum level of reimbursement for medical care of patients insured under Maricopa Foundation-endorsed health insurance plans for other surgical procedures.

193. On or about May 20, 1975, the Chairman of the Foundation's Fee Schedule Committee asked the presidents of various groups of doctors to designate representatives to meet with the Committee in order to propose changes, additions or deletions in the unit values used by the Foundation.

The Maricopa Foundation only admits that on or about May 20, 1975, the Chairman of the Maricopa Foundation Fee Schedule Committee asked the presidents of physician specialty societies to submit names of two or three of their member physicians who would be willing to meet with the Committee to propose any changes, additions or deletions to the Maricopa Foundation's conversion factors used to establish maximum reimbursable allowances for services to patients insured under Maricopa Foundation-endorsed health insurance plans that would reflect the practice patterns of each specialty.

194. On or about May 20, 1975, three members of the Foundation's Board of Trustees held a meeting with the Foundation's Fee Schedule Committee at which the collection of data on doctors' fees in connection with the preparation of the Foundation fee schedule for 1976 was discussed.

The Maricopa Foundation only admits that two members of its Board of Trustees and its Executive Director met with its Fee Schedule Committee on or about May 20, 1975 and they discussed the possibility of increasing conversion factors used to determine maximum levels of reimbursement for medical care of patients insured under Maricopa Foundation-endorsed health insurance plans.

195. On or about May 30, 1975, the Foundation's Executive Director met with the Foundation's Fee Schedule Committee concerning the possibility of increasing the Foundation fee schedule.

See the response to statement 194 herein.

196. On or about May 30, 1975, the Foundation's Executive Director met with the Foundation's Fee Schedule Committee concerning the Committee's progress in developing a relative value schedule for Arizona doctors.

The Maricopa Foundation only admits that two members of its Board of Trustees and its Executive Director met with its Fee Schedule Committee on or about May 20, 1975 and they discussed the progress of Dr. Moraca in developing a relative value schedule for use in Arizona.

197. In or about June, 1975, *Round-Up* published summaries of determinations of the society's Grievance Committee which approved doctors' fees billed in accordance with the relative value schedules used by the Foundation.

The Maricopa Foundation has no information sufficient to admit or deny the truth or falsity of this statement and refers plaintiff to the response provided by the Maricopa County Medical Society.

198. On or about April 8, 1975, the Foundation's Board of Trustees appointed a delegate to report to the Society's Board of Directors on the activities of the Foundation.

The Maricopa Foundation only admits that on or about March 18, 1975, its Board of Trustees appointed one of its members to inform the Board of Directors of the Maricopa County Medical Society of the Maricopa Foundation's activities.

199. Beginning on or about April 8, 1975, minutes of meetings of the Foundation's Board of Trustees were sent to members of the Society's Board of Directors.

The Maricopa Foundation only admits that for a period beginning on or about April 8, 1975 and continuing thereafter for two or three months, the Maricopa Foundation transmitted copies of the minutes of its Board of trustees to the Board of Directors of the Maricopa County Medical Society.

200. On or about May 13, 1975, a representative of the Foundation read the minutes of a previous meeting of the Foundation's Board of trustees at a meeting of the Society's Board of Directors.

Admit.

201. On or about June 10, 1975, a representative of the Foundation reported to the Society's Board of Directors on the activities of the Foundation.

Admit.

202. The Foundation's functions were discussed at a joint meeting of the Foundation's Board of Trustees and the Society's Board of Directors on or about July 8, 1975.

Admit.

203. Members of the Society's Board of Directors toured the Foundation's facilities on or about July 8, 1975.

Admit.

204. In or about August, 1971, representatives of the Foundation attended a meeting of the American Association of Foundations for Medical Care in Vail, Colorado.

The Maricopa Foundation only admits that its representatives attended a meeting of the American Association of Foundations for Medical Care held in Vail, Colorado in August 1973.

205. In or about August, 1971, a representative of the Foundation was elected Vice President of a regional Association of Foundations for Medical Care.

Admit only that in or about August 1971 a representative of the Maricopa Foundation was elected Vice President of the American Association of Foundations for Medical Care.

206. In or about June or July 1973, a representative of the Foundation attended a regional meeting of the American Association of Foundations for Medical Care at Mackinac Island, Michigan.

Admit.

207. On or about July 17, 1973, the Foundation's Board of Trustees heard a report concerning a regional meeting of the American Association of Foundations for Medical Care at Mackinac Island, Michigan from a Foundation representative who attended that meeting.

Admit.

208. In or about November, 1973, the Foundation's Executive Director attended a meeting of the American Association of Foundations for Medical Care in San Diego, California.

Admit.

209. In or about January or February of 1974, a representative of the Foundation attended a Board meeting of the American Association of Foundations for Medical Care.

Admit.

210. On or about February 26, 1974, the Foundation's Board of Trustees heard a report concerning a Board meeting of the American Association of Foundations for Medical Care from a Foundation representative who attended that meeting.

Admit.

211. On or about February 26, 1974, materials obtained from the American Association of Foundations for Medical Care were distributed to the Foundation's Board of Trustees.

Admit.

212. From approximately September 29, 1974 through October 2, 1974, the Foundation's President attended a meeting of the American Association of Foundations for Medical Care in Washington, D.C.

The Maricopa Foundation only admits that from approximately September 29, 1974 through October 2, 1974 its Vice President attended a meeting of the American Association of Foundations for Medical Care in Washington, D. C.

213. A representative of the Foundation was a member of the Health Insurance Committee of the American Association of Foundations for Medical Care in 1975.

Admit.

214. A representative of the Foundation was a member of the Insurance Industry Liaison Committee of the American Association of Foundations for Medical Care in 1975.

Admit.

215. In or about August, 1975, a representative of the Foundation attended a meeting of the American Association of Foundations for Medical Care in San Francisco, California.

Admit.

216. In or about August, 1975 a representative of the Foundation chaired a meeting of the Insurance Industry Liaison Committee of the American Association of Foundations for Medical Care in San Francisco, California.

Admit.

217. At a meeting of the American Association of Foundations for Medical Care in San Francisco, California in or about August 1975, a representative of the Foundation obtained materials prepared by California medical societies regarding increases in doctor's fees and the impact of such increases on premiums for Foundation Plans.

The Maricopa Foundation only admits that a representative of the Maricopa Foundation who attended a meeting of the American Association of Foundations for Medical Care in San Francisco, California in August 1975 received copies of material distributed by California Medical Societies which reflected increases in physicians' fees in California that had been necessitated by increased malpractice insurance premiums.

218. On or about August 18, 1975, the Foundation's Board of Trustees heard a report concerning a meeting of the American Association of Foundations for Medical Care in San Francisco, California in August, 1975 from a Foundation representative who attended that meeting.

Admit.

219. On or about August 18, 1975, materials from California medical societies regarding increases in doctors fees and the impact of such increases on premiums for Foundation Plans were distributed to the Foundation's Board of Trustees.

Denied. See Minutes of the Board of Trustees of the Maricopa Foundation dated August 18, 1975.

220. On or about August 18, 1975, the Foundation's Board of Trustees directed that a meeting of the Foundation's Insurance Advisory Committee be scheduled to consider, among other things, increases in the Foundation fee schedule.

The Maricopa Foundation only admits that on or about August 18, 1975, the Maricopa Foundation's Board of Trustees directed that a meeting of the Foundation's Insurance Advisory Committee be scheduled to consider, among other things, changes in the Foundation maximum reimbursable level of compensation payable by the insurer to

doctors for services provided to patients insured under Maricopa Foundation-endorsed medical health insurance plans. *See* Minutes of the Board of Trustees of the Maricopa Foundation dated August 18, 1975.

221. On or about August 19, 1975, materials prepared by foundations for medical care in the State of California concerning increases in doctor's fees were sent to members of the Foundation's Board of Trustees by Foundation employees.

Admit.

222. On or about September 9, 1975, a representative of the Foundation discussed the Foundation's activities at a joint meeting of the Boards of Directors of the Society and the Bureau of Medical Economics.

Admit.

223. On or about September 9, 1975, the Foundation's Insurance Advisory Committee discussed possible increases in the Foundation fee schedule for 1976.

Admit only that on or about September 9, 1975, the Foundation's Insurance Advisory Committee discussed possible increase in the maximum reimbursable level of compensation payable by the insurer to doctors for services provided to patients insured under Maricopa Foundation-endorsed health insurance plans in 1976.

224. On or about September 15, 1975, the Foundation's Board of Trustees discussed the possibility of increasing deductibles on Foundation Plans to offset the increase in premiums that would otherwise be caused by the expected increases in the Foundation fee schedule for 1976.

Admit only that on or about September 15, 1975, the Foundation's Board of Trustees discussed the possibility of increasing deductibles on Maricopa Foundation-endorsed plans to offset the increase in premiums that would otherwise be caused by the expected increase in the maximum reimbursable level of compensation payable by the insurer

to the doctors for services provided to patients insured under Maricopa Foundation-endorsed health insurance plans in 1976.

225. In or about October, 1975, the Foundation conducted a survey among its members to determine their usual fees for doctors' services.

Admit.

226. On or about October 20, 1975, the Foundation's Board of Trustees reviewed the results of the Foundation's fee survey of its membership.

Admit.

227. On or about October 20, 1975, the Foundation's Board of Trustees reviewed the results of a fee survey conducted by the Arizona Medical Association in the fall of 1975.

Admit.

228. On or about October 20, 1975, the Foundation's Board of Trustees approved for submission to Foundation members a proposed Foundation fee schedule for 1976.

Admit only that on or about October 20, 1975, the Foundation's Board of Trustees approved for vote by the participating and cooperating members of the Foundation proposed changes to maximum reimbursable levels of compensation to doctors providing medical services to patients insured under Maricopa Foundation-endorsed health insurance plans for 1976.

229. The Foundation fee schedule effective in 1975 included unit conversion factors of:

(a) 10.00 for medicine;
(b) 8.50 for surgery;
(c) 6.50 for laboratory;
(d) 7.50 for radiology with a professional component of $1.70;
(e) 10.00 for anesthesiology.

Maricopa Foundation only admits that the conversion factors used by Maricopa Foundation to calculate maximum reimbursable levels of compensation payable by the insurer to doctors for services provided to patients insured under Maricopa Foundation-endorsed health insurance plans which became effective in 1975 are as stated in statement 229.

230. The results of the Arizona Medical Association's 1975 fee survey which the Foundation's Board of Trustees reviewed indicated that the average unit conversion factor of respondents was:

(a) 10.21 for medicine;
(b) 9.28 for surgery;
(c) 7.51 for laboratory;
(d) 8.10 for radiology with a professional component of $1.73;
(e) 12.28 for anesthesiology.

The Maricopa Foundation only admits that the Minutes of its Board of Trustees reflects that the Arizona Medical Association's 1975 fee survey indicated that the average conversion factor representative of fees charged by physicians within the State of Arizona for medicine was $10.20; for surgery was $9.28 and for anesthesia was $12.30.

231. The results of the Arizona Medical Association's 1975 fee survey which the Foundation's Board of Trustees reviewed indicated that the median unit conversion factor of respondents was:

(a) 10 for medicine;
(b) 9 for surgery;
(c) 7 for laboratory;
(d) 7.50 for radiology with a professional component of $1.65;
(e) 12 for anesthesiology.

See response to statement 230 herein.

232. The results of the Arizona Medical Association's 1975 fee survey which the Foundation's Board of Trustees reviewed indicated that the mode or most frequent unit conversion factor of respondents was:

(a) 10 for medicine;
(b) 8.50 for surgery;
(c) 6.50 for laboratory;
(d) 7.50 for radiology with a professional component of $1.65;
(e) 12.00 for anesthesiology.

See response to statement 230 herein.

233. The proposed Foundation fee schedule for 1976 included unit conversion factors of:

(a) 11 for medicine:
(b) 9.50 for surgery;
(c) 7 for laboratory;
(d) 8 for radiology with a professional component of $1.85;
(e) 12 for anesthesiology.

Maricopa Foundation only admits that the conversion factors used by Maricopa Foundation to calculate maximum reimbursable levels of compensation payable by the insurer to doctors for services provided to patients insured under Maricopa Foundation-endorsed health insurance plans which became effective in 1976 are as stated in statement 233.

234. The proposed Foundation fee schedule for 1976 was adopted by the Foundation effective January 1, 1976.

Admit only that effective January 1, 1976 maximum reimbursable levels of compensation to doctors providing medical services to patients insured under Maricopa Foundation-endorsed health insurance plans were changed in accordance with the conversion factors referred to in statement 233.

235. On or about October 27, 1975, the Foundation sent ballots for approval of the proposed Foundation fee schedule for 1976 to Foundation members.

The Maricopa Foundation only admits that on or about October 27, 1975, the Maricopa Foundation sent ballots to its members for the approval or disapproval of conversion factors proposed for use in 1976 in determining the maximum level of reimbursement payable to physicians for services rendered to patients insured under Maricopa Foundation-endorsed plans.

236. On or about October 31, 1975, the Foundation informed Blue Cross and Blue Shield of Arizona of increases in the Foundation fee schedule to be effective January 1, 1976.

Admit only that on or about October 31, 1975 the Maricopa Foundation informed Blue Cross and Blue Shield of Arizona of increases in the maximum level of reimbursement payable to physicians for services rendered to patients insured under Maricopa Foundation-endorsed plans to be effective January 1, 1976.

237. At a meeting of the Foundation's Board of Trustees on or about November 17, 1975, representatives of the Phoenix Psychiatric Council requested that the Foundation's minimum standards be revised to provide for coverage of additional outpatient psychiatric services.

Admit only that at a meeting of Maricopa Foundation's Board of Trustees on or about November 17, 1975, representatives of the Phoenix Psychiatric Council requested that Maricopa Foundation's minimum standards for endorsed health insurance plans be revised to provide for coverage of additional outpatient psychiatric services.

238. On or about November 17, 1975, the Foundation's Board of Trustees approved the revisions requested by the Phoenix Psychiatric Council in the Foundation's minimum standards to provide for coverage of outpatient psychiatric services.

Admit only that on or about November 17, 1975 Maricopa Foundation's Board of Trustees approved the revisions requested th the Phoenix Psychiatric Council in the Maricopa Foundation's minimum standards for endorsed health insurance plans to provide for coverage of outpatient psychiatric services.

239. On or about October 20, 1975, the Foundation's Board of Trustees discussed the Foundation's development of a relative value schedule for Arizona's doctors.

The Maricopa Foundation only admits that on or about October 20, 1975 its Board of Trustees discussed the Arizona relative value schedule that was being prepared by Patrick Moraca, M.D.

240. In or about December, 1975, *Round-Up* published a report on the adoption of the Foundation fee schedule for 1976.

The Maricopa Foundation has no information sufficient to admit or deny the truth or falsity of this statement and refers plaintiff to the response provided by the Maricopa Society.

241. In or about December, 1975, *Round-Up* published a report on the Foundation's development of a relative value schedule for Arizona doctors.

The Maricopa Foundation has no information sufficient to admit or deny the truth or falsity of this statement and refers plaintiff to the response provided by the Maricopa Society.

242. In or about December, 1975, *Round-Up* published a report on a pending lawsuit against the American Society of Anesthesiologists for a declaratory judgment against the use of relative value schedules.

The Maricopa Foundation has no information sufficient to admit or deny the truth or falsity of this statement and refers plaintiff to the response provided by the Maricopa Society.

243. On or about January 10, 1976, a representative of the Foundation described the Foundation's development of a relative value schedule for Arizona doctors at a meeting of the Board of Directors of the Arizona Medical Association.

The Maricopa Foundation is without information sufficient to admit or deny the truth or falsity of this statement.

244. Representatives of the county medical societies of Cochise, Coconino, Maricopa and Pima Counties, the Foundation and Pima Foundation attended the meeting of the Board of Directors of the Arizona Medican Association on or about January 10, 1976.

The Maricopa Foundation is without information sufficient to admit or deny the truth or falsity of this statement.

245. On or about January 13, 1976, the Society's Board of Directors elected three new trustees to the Foundation's Board of Trustees at a joint meeting of the Boards of Directors of the Society and the Bureau of Medical Economics.

The Maricopa Foundation only admits that in or about January 1976 its administrative members elected four new trustees to the Maricopa Foundation's Board of Trustees.

246. On or about February 6, 1976, the Foundation's Executive Director sent a written report to the Foundation's President outlining the course of action that culminated in the adoption of the Foundation fee schedule effective January 1, 1976.

Admit only that on or about February 6, 1976, Maricopa Foundation's Executive Director sent a written report to the Maricopa Foundation's President outlining the various

activities that culminated in adoption of new maximum levels of reimbursement payable to physicians for services rendered to patients insured under Maricopa Foundation-endorsed plans effective January 1, 1976.

247. On or about April 13, 1976, the Arizona Podiatry Association recommended five podiatrists to serve on the Foundation's review committee for podiatry services.

Admit.

248. On or about April 13, 1976, the podiatrists who were performing peer review for the Foundation met to discuss the unit values for various podiatry services.

Admit.

249. In or about June, 1976, the Foundation surveyed various groups of doctors concerning recommended increases in the Foundation fee schedule.

Denied. Upon information and belief, the Maricopa Foundation did not survey groups of doctors with respect to the Maricopa Foundation's conversion factors in or about June 1976. *See* response to statement 250 herein.

250. On or about June 6, 1976, the Arizona Society of Otolaryngology recommended a 10 percent increase in the Foundation fee schedule to 10.5.

The Maricopa Foundation only admits that by letter dated June 6, 1976, the Arizona Society of Otolaryngology recommended an increase in the surgical conversion factor used by Maricopa Foundation to determine the maximum level of reimbursement payable to doctors for surgical services performed on patients insured under a Maricopa Foundation-endorsed health insurance plan to a range of 10.0 to 11.0, which that society calculated to be an increase of approximately ten percent. The Maricopa Foundation further states that because of the location of said letter in its files, it believes that the author intended the date to be June 6, 1977.

251. On or about July 19, 1976, the Chairmen of the Foundation's Fee Schedule Committee reported to the Foundation's Board of Trustees on a meeting of said Chairman with plastic surgeons in the community concerning coverage of plastic surgery under Foundation Plans.

Admit.

252. On or about July 19, 1976, the Foundation's Board of Trustees appointed four plastic surgeons to a committee to make recommendations to the Board on coverage for plastic surgery under Foundation Plans.

Denied. The Maricopa Foundation admits that the minutes of its Board of Trustees dated July 19, 1976 reflect that four plastic surgeons were appointed by the plastic surgeons to outline to the Maricopa Foundation their recommendations for coverage of plastic surgery under the Maricopa Foundation minimum standards.

253. On or about August 13, 1976, the Foundation asked the Central Arizona Orthopedic Society for its opinion on the certification of in-patient benefits for ganglionectomy.

Admit.

254. From about 1973 until August 13, 1976 the Foundation denied inpatient benefits for ganglionectomies.

The Maricopa Foundation admits that the letter of Laurance B. Nilsen to Richard Daley dated August 13, 1976 reflects that it had been the policy of the Maricopa Foundation from 1973 to date to deny benefits for overnight hospitalization for simple ganglion resection.

255. On or about September 20, 1976, the Foundation's Board of Trustees discussed the unit value of 20 used by the Foundation for diagnostic laparoscopy.

Admit.

256. On or about September 20, 1976, the Foundation's Board of Trustees directed that the Foundation obtain the opinion of the Phoenix OB-GYN Society on the usual doctor's fee for diagnostic laparoscopy.

Admit.

257. On or about October 7, 1976, the Phoenix OB-GYN Society informed the Foundation of the unanimous agreement of members of the Phoenix OB-GYN Society that the unit value used by the Foundation for diagnostic laparoscopy should be increased from 20 to 35.

Admit.

258. On or about October 12, 1976, the Foundation's Board of Trustees referred to the Foundation's Fee Schedule Committee the opinion of the Phoenix OB-GYN Society on the usual doctor's fee for diagnostic laparoscopy.

Admit.

259. In or about November, 1976, the Foundation's Board of Trustees received a complaint from the President of the Arizona Internal Medicine Society that that Society had not been consulted with respect to the Foundation's 1976 fee schedule.

Admit only that in or about November 1976 the Foundation's Board of Trustees was informed by the President of the Arizona Internal Medicine Society that it had not been consulted with respect to the maximum level of reimbursement payable for services performed on patients insured under a Maricopa Foundation-endorsed health insurance plan proposed for 1976.

260. On or about November 19, 1976, the Foundation's Board of Trustees directed that the Internal Medicine Society should be consulted on the same basis as other doctors' groups before a new Foundation fee schedule was approved.

Admit only that on or about January 19, 1976 the Foundation's Board of Trustees decided that the Internal Medicine Society would be given an opportunity to discuss proposed changes in the maximum level of reimbursement payable for services performed on patients insured under a Maricopa Foundation-endorsed health insurance plan before such changes were submitted to the Foundation membership.

261. In or about November, 1976, the Foundation conducted a survey of fees charged for coronary bypass surgery among doctors who performed such surgery.

Admit only that in or about November 1976, Maricopa Foundation conducted a survey of fees charged in Maricopa County for coronary bypass surgery by doctors who perform such surgery.

262. On or about November 29, 1976, the Foundation's Physicians Review Committee recommended that the mean of the fees charged for corony bypass surgery be set as the allowable payment for such surgery under Foundation Plans.

Admit only that on or about November 29, 1976 Maricopa Foundation's Physicians Review Committee recommended that the mean of the usual and customary fees charged for coronary bypass surgery by doctors who perform such surgery in Maricopa County should be designated the maximum level of reimbursement payable to physicians for such surgery rendered to patients insured under Maricopa Foundation-endorsed plans.

263. In or about November, 1976, the Foundation's Board of Trustees set the unit values to be used by the Foundation for coronary bypass surgery, at 200 units for single bypass surgery, 225 units for double bypass surgery and 250 units for triple bypass surgery.

The Maricopa Foundation admits that the minutes of its Board of Trustees dated December 20, 1976 reflect that the Board adopted the above-stated unit values for the above-stated procedures.

264. At a joint meeting of the Boards of Directors of the Society and the Bureau of Medical Economics on or about December 14, 1976, the Society's Board of Directors elected nine trustees to three-year terms on the Foundation's Board of Trustees.

The Maricopa Foundation only admits that in or about December 1976 its administrative members elected nine new trustees to the Maricopa Foundation's Board of Trustees.

265. On or about December 17, 1976, the Chairman of the Foundation's Fee Schedule Committee directed the Foundation's staff to increase the Foundation's allowable fee for diagnostic laparoscopy.

The Maricopa Foundation only admits that on or about December 17, 1976 a Chairman of the Maricopa Foundation's Fee Schedule Committee left a telephone message for a Maricopa Foundation employee recommending that the Maricopa Foundation's maximum level of reimbursement for laparoscopy performed on patients insured under Maricopa Foundation-endorsed health insurance plans should be increased.

266. On or about December 22, 1976, the Chairman of the Procedures and Fees Committee of the Phoenix OB-GYN Society informed the Chairman of the Foundation's Physicians Review Committee that diagnostic laparoscopy should not be considered a routine procedure.

The Maricopa Foundation only admits that on or about December 22, 1976, the Chairman of the Procedure and Fees Committee of the Phoenix OB-GYN Society informed the Chairman of the Maricopa Foundation's Physicians

Review Committee that a pap smear is not a routine screening procedure "if obtained for colposcopically suggested or tissue proven dysplasia, carcinoma in situ, and invasive carcinoma of the vagina, vulva or cervix."

267. At a joint meeting of the Boards of Directors of the Society and the Bureau of Medical Economics on or about January 11, 1977, the Society's Board of Directors elected one trustee to fill a vacancy on the Foundation's Board of Trustees.

The Maricopa Foundation only admits that in or about January 1977 its administrative members elected one trustee to fill a vacancy on the Maricopa Foundation's Board of Trustees.

268. On or about February 21, 1977, the Foundation had 1,052 members.

Admit.

269. Between September, 1976 and February, 1977 the Phoenix OB-GYN Society surveyed its member on their prices for diagnostic laparoscopy and tubal laparoscopy and conveyed their responses to the Foundation.

Admitted.

270. The median fee for diagnostic laparoscopy reported in the survey of the Phoenix OB-GYN Society was $250.

Admit.

271. The average fee for diagnostic laparoscopy reported in the survey of the Phoenix OB-GYN Society was $266.05.

Admit.

272. On or about February 21, 1977, the Foundation's Board of Trustees set the Foundation's allowable fee for diagnostic laparoscopy at $275.

The Maricopa Foundation only admits that on or about February 21, 1977, its Board of Trustees voted to increase the unit value of diagnostic laparoscopy to 29 units which given the current conversion factor resulted in a maximum

level of reimbursement payable to physicians for a diagnostic laparoscopy of $275 for such a procedure on a patient insured under a Maricopa Foundation-endorsed plan.

273. The allowable fee for diagnostic laproscopy which the Foundation's Board of Trustees approved on or about February 21, 1977 had been recommended by the Phoenix OB-GYN Society.

Denied. On or about October 7, 1976, by letter from the president of the Phoenix OB-GYN Society to the Maricopa Foundation, that Society recommended that the unit value of a diagnostic laparoscopy be advanced to 35 units. On or about February 21, 1977, the Maricopa Foundation's Board of Trustees voted to set the unit value of diagnostic laparoscopies at 29 units.

274. The median fee for tubal laparoscopy reported in the survey of the Phoenix OB-GYN Society was $300.

Admit.

275. The average fee for tubal laparoscopy reported in the survey of the Phoenix OB-GYN Society was $315.53.

Admit.

276. On or about February 21, 1977, the Foundation's Board of Trustees set the Foundation's allowable fee for tubal laparoscopy at $325.

The Maricopa Foundation only admits that on or about February 21, 1977, its Board of Trustees voted to reduce the unit value for tubal ligation by laparoscopy to 34 units which given the current conversion factor resulted in a reduction in the maximum level of reimbursement payable to physicians for a tubal laparoscopy from $380 to $325 for such a procedure on a patient insured under a Maricopa Foundation-endorsed plan.

277. The allowable fee for tubal laparoscopy which the Foundation's Board of Trustees approved on or about February 21, 1977 had been recommended by the Phoenix OB-GYN Society.

Denied.

278. On or about March 17, 1977, the Foundation's Ad Hoc Finance Committee discussed various ways to spend the Foundation's excess funds, including continuation of the Foundation's development of a relative value schedule for Arizona doctors.

The Maricopa Foundation only admits that on or about March 7, 1977, the Maricopa Foundation's Ad Hoc Finance Committee discussed various ways to spend the Maricopa Foundation's accumulated funds including the establishment of a Foundation Relative Value Schedule.

279. On or about March 21, 1977, the Foundation's Board of Trustees agreed to consult various groups of doctors in April and May of 1977 concerning the Foundation fee schedule for 1978.

The Maricopa Foundation only admits that on or about March 21, 1977, its Board of Trustees directed that specialty societies be consulted in April and May of 1977 so that by June of 1977 the Board would have material available to determine new conversion factors to be used by the Maricopa Foundation to determine maximum levels of reimbursement payable to doctors for services performed on patients insured under a Maricopa Foundation-endorsed plan in the future.

280. On or about March 21, 1977, the Foundation's Board of Trustees agreed that the information needed to prepare the Foundation fee schedule for 1978 should be obtained by June, 1977.

See response to statement 279 herein.

281. On or about April 11, 1977, the Foundation asked various groups of doctors to review with their members the usual or customary fees their members charged.

The Maricopa Foundation only admits that on or about April 14, 1977, it asked various groups of doctors to review with their members the then-current conversion factors used by the Maricopa Foundation to determine maximum levels of reimbursement payable to doctors for services performed on patients insured under a Maricopa Foundation-endorsed plan and to advise the Maricopa Foundation of any changes the members thought would be appropriate.

282. On or about April 14, 1977, the Foundation asked various groups of doctors to report the results of their fee surveys to the Foundation so that the Foundation's new fee schedule would be as close as possible to the usual fees for doctor's services in the community.

The Maricopa Foundation only admits that on or about April 14, 1977 it asked various groups of doctors to review with their members the then-current conversion factors used by the Maricopa Foundation to determine maximum levels of reimbursement payable to doctors for services performed on patients insured under a Maricopa Foundation-endorsed plan and to advise the Maricopa Foundation of any changes the members thought would be appropriate in order to maintain as close-as-possible relationship between the maximum allowance for Maricopa Foundation-endorsed plans and the usual and customary charges made by physicians in the area.

283. On or about April 14, 1977, the Foundation asked the Procedures and Fees Committee of the Phoenix OB-GYN Society to determine the unit value that should be accorded a certain type of surgery.

The Maricopa Foundation only admits that on or about April 14, 1977 it asked the Procedures and Fees Committee of the Phoenix OB-GYN Society for advice with respect to the appropriateness of the relative value attributed a cer-

tain surgical procedure in the 1964 California Relative Value Schedule to determine maximum levels of reimbursement payable to doctors for services performed on patients insured under a Maricopa Foundation-endorsed plan.

284. On or about May 16, 1977, the Maricopa Plastic Surgeons informed the Foundation of a meeting they held at the Foundation's request.

The Maricopa Foundation only admits that on or about May 16, 1977 the Maricopa Plastic Surgeons Society informed the Maricopa Foundation that that group had held a recent meeting and that it had discussed a letter received by the group from the Medical Foundation's president.

285. On or about May 16, 1977, the Maricopa Plastic Surgeons recommended to the Foundation that the Foundation's unit conversion factor for surgery should be 10 and the Foundation should use the 1969 or 1974 edition (rather than the 1964 edition) of the California Relative Value Schedule.

Admit only that on or about May 16, 1977 the Maricopa Plastic Surgeons Society recommended to Maricopa Foundation that the conversion factor used by Maricopa Foundation for determining maximum levels of reimbursement payable to doctors for surgery performed on patients insured under a Maricopa Foundation-endorsed plan should be 10 and that the Maricopa Foundation should establish those maximum reimbursement levels with reference to the 1969 or 1974 edition of the California Relative Value Schedule rather than the 1964 edition.

286. On or about April 18, 1977, the Foundation's President reported to the Foundation's Board of Trustees that he had asked various doctors' groups to report to the Foundation the usual fees their members charged and their complaints regarding the Foundation fee schedule.

Admit only that on or about April 18, 1977 the Maricopa Foundation's President reported to its Board of Trustees that he had asked various doctors groups to report to the Maricopa Foundation as to the usual and customary fees of doctors in Maricopa County and to report any complaints regarding the maximum levels of reimbursement payable to doctors for services to patients insured under a Maricopa Foundation-endorsed plan.

287. On or about April 18, 1977, the Foundation's President informed the Foundation's Board of Trustees that preparation of the Foundation fee schedule for 1978 would begin after the Foundation received reports from various doctors' groups.

The Maricopa Foundation only admits that its president reported to its Board of Trustees that upon receiving information from the specialty societies, the Maricopa Foundation would discuss changes in the maximum levels of reimbursement payable to doctors for medical services performed on patients insured under a Maricopa Foundation-endorsed plan with its insurance advisors and make further reports to the Board.

288. On or about April 22, 1977, the President of the Phoenix Radiological Society reported to the Foundation that radiologists would not use a relative value schedule but would bill their own fees as required by a consent decree signed by the American College of Radiology.

The Maricopa Foundation only admits that by letter dated April 22, 1977 the president of the Phoenix Radiological Society informed the Maricopa Foundation that radiologists would bill their usual and customary fees without reference to a relative value schedule. No reference was made by the author of that letter to any consent decree signed by the American College of Radiology.

289. During the week of April 23, 1977, the Executive Director of the Foundation attended a discussion of the Federal Trade Commission's position that the use of relative value schedules by doctors is a violation of the federal antitrust laws.

Maricopa Foundation objects to this statement as beyond the scope of Rule 26(b).

290. On or about May 16, 1977, the Foundation's Board of Trustees declined to act on revision of the Foundation fee schedule because the Foundation's staff had not yet collated the opinions and reports of doctors' groups regarding such revisions.

Admit only that on or about May 16, 1977 the Maricopa Foundation's Board of Trustees determined that it should not revise the maximum levels of reimbursement payable to doctors for medical services performed on patients insured under a Maricopa Foundation-endorsed health insurance plan until information concerning usual and customary fees had been accumulated from medical specialty societies and others.

291. On or about May 24, 1977, the Phoenix Urology Society reported to the Foundation that a poll of its members showed that most charged a unit conversion factor of 10 to 11, a few charged 12, and one charged 9.5.

Admit only that on or about May 26, 1977 the President of the Phoenix Urological Society wrote to the President of Maricopa Foundation that a survey of its members revealed that most charged a usual and customary fee which would approximate a conversion factor of 10 to 11, a few would approximate 12 and one would approximate 9.5 using the equivalent of the 1964 California Relative Value Schedule.

292. On or about May 24, 1977, the Phoenix Urological Society reported to the Foundation that its members considered some procedures inadequately reimbursed under the relative conversion schedule used by the Foundation.

Admit only that on or about May 26, 1977 the President of the Phoenix Urological Society wrote to the President of Maricopa Foundation that its members considered some medical procedures inadequately reimbursed under the unit values used by Maricopa Foundation to determine maximum levels of reimbursement payable to doctors for services to patients insured under a Maricopa Foundation-endorsed health insurance plan.

293. On or about May 27, 1977, the President of the Arizona Society of Internal Medicine recommended to the Foundation that the unit conversion factor for medicine be increased _____ on the Foundation fee schedule for 1978.

Admit only that on or about May 27, 1977 the President of the Arizona Society of Internal Medicine wrote to Maricopa Foundation that the conversion factor used by Maricopa Foundation to determine maximum levels of reimbursement payable to doctors for medical services to patients insured under a Maricopa Foundation-endorsed health insurance plan should be increased in 1978.

294. On or about June 1, 1977, the premium on the Society's group insurance trust was doubled over the premium for the preceding year.

Admitted.

295. On or about June 6, 1977, the Chairman of the Phoenix OB-GYN Society reported to the Foundation that the Executive Committee of the Phoenix OB-GYN Society believed the unit conversion factor for medicine should be 10.5 on the Foundation fee schedule for 1978.

The Maricopa Foundation only admits that the Secretary-Treasurer of the Phoenix OB-GYN Society informed the Maricopa Foundation by letter dated June 6, 1977 that the Executive Committee of the Phoenix OB-GYN Society felt that the conversion factor for surgery used by Maricopa

Foundation to determine maximum levels of reimbursement payable to doctors for surgical services to patients insured under a Maricopa Foundation-endorsed health insurance plan should be increased to 10.50.

296. On or about June 6, 1977, the Chairman of the Phoenix OB-GYN Society reported to the Foundation the recommendation of the Procedures and Fees Committee of the Phoenix OB-GYN Society that the unit values accorded a certain surgical procedure on the relative value schedule used by the Foundation should be increased from to 50.

The Maricopa Foundation only admits that by letter dated June 6, 1977 the Chairman of the Procedures and Fees Committee of the Phoenix OB-GYN Society informed the Maricopa Foundation that it was the consensus of his committee that the relative value of the Marshall-Marchetti procedure used by Maricopa Foundation to determine maximum levels of reimbursement payable to doctors for performing the Marshall-Marchetti procedure on patients insured under a Maricopa Foundation-endorsed health insurance plan should be increased to 50.

297. On or about June 7, 1977, the Foundation sent questionnaires to Foundation members concerning their opinions on the Foundation fee schedule for 1978.

The Maricopa Foundation only admits that on or about June 7, 1977 the Maricopa Foundation surveyed its members asking them to indicate a single conversion factor in each member's practice category and relative value schedule which would approximate that member's usual and customary fees for medical services.

298. In or about June, 1977, the Foundation informed Foundation members that they would receive ballots for approval of a revised Foundation fee schedule as soon as the Foundation tabulated its membership poll.

Admit only that in or about June 1977 the Maricopa Foundation informed its members they would receive mail ballots to vote on the adoption of revised maximum reimbursable levels of compensation to doctors providing medical services to patients insured under Maricopa Foundation-endorsed health insurance plans as soon as the Maricopa Foundation tabulated the survey of usual and customary fees for medical services.

299. In or about June, 1977, the Foundation indicated to Foundation members that the Foundation fee schedule for 1978 should approximate the majority of doctors' charges.

The Maricopa Foundation only admits that by letter dated June 7, 1977 it stated to its membership that the Maricopa Foundation's maximum reimbursable levels of compensation to doctors providing medical services to patients insured under Maricopa Foundation-endorsed health insurance plans should approximate the majority of physician charges "but could not be considered usual and customary fees for medical services in Maricopa County."

300. On or about June 17, 1977, the Gastrointestinal Association suggested a conversion factor of 11 for medicine on the Foundation fee schedule for 1978.

The Maricopa Foundation only admits that on or about June 17, 1977 a letter was written by four physicians doing business as Gastrointestinal Associates, P.A. suggesting that medical diagnostic procedures listed under surgery should be reclassified under medicine and be allotted a conversion factor of 11 for the purpose of determining the Maricopa Foundation's maximum reimbursable levels of compensation to doctors performing those procedures on patients insured under Maricopa Foundation-endorsed health insurance plans.

301. On or about June 21, 1977, the Foundation's Board of Trustees heard a report on its fee survey of Foundation members.

Admit only that on or about June 21, 1977 the Board of Trustees of Maricopa Foundation received a report on its survey of Maricopa Foundation members as to their usual and customary fees for medical services.

302. On or about June 21, 1977, the Foundation's Board of Trustees discussed various methods of increasing the Foundation fee schedule for 1978.

Admit only that on or about June 21, 1977 the Board of Trustees of the Maricopa Foundation discussed various methods of increasing the Maricopa Foundation's maximum reimbursable levels of compensation to doctors providing medical services to patients insured under Maricopa Foundation-endorsed health insurance plans.

303. A Foundation fee schedule effective December 1, 1977 was adopted in or before October, 1977.

Admit only that in or before October 1977 Maricopa Foundation adopted revised maximum reimbursable levels of compensation to doctors providing medical services to patients insured under Maricopa Foundation-endorsed health insurance plans effective December 1, 1977.

304. The Foundation fee schedule effective December 1, 1977 included unit conversion factors of:

(a) 12.25 for medicine;
(b) 10.50 for surgery;
(c) 7.50 for laboratory;
(d) 8.50 for radiology with a professional component of $1.85;
(e) 13.25 for anesthesiology.

Admit only that the conversion factors used by Maricopa Foundation to calculate maximum reimbursable levels of compensation payable by the insurer to doctors for services provided to patients insured under Maricopa Foundation-endorsed health insurance plans effective December 1, 1977 are as stated in statement 304.

305. In or about September, 1977, Foundation representative(s) discussed changes in the Foundation's criteria for podiatry claims with members of the Foundation's Peer Review Committee for Podiatry.

The Maricopa Foundation only admits that on or about December 21, 1977 it transmitted criteria for podiatry peer review to the chairman of the Maricopa Foundation's Peer Review Committee for Podiatry.

306. The members of the Foundation's Peer Review Committee for Podiatry had been nominated by the Arizona Podiatry Association.

The Maricopa Foundation only admits that some of the persons nominated by the Arizona Podiatry Association by letter dated April 13, 1976 from the Secretary of the Arizona Podiatry Association to the Maricopa Foundation served on the Maricopa Foundation's Peer Review Committee for Podiatry.

307. On or about January 26, 1978, the Foundation's Executive Director informed the Arizona Director of Insurance that is no case does the Foundation act as an insurer or write checks on its own account in payment of claims under Foundation Plans.

The Maricopa Foundation admits that on or about January 26, 1978, its Executive Director informed the Arizona Director of Insurance that "[i]n no case does the Foundation act as an insurance company or write checks on its own account" in payment of claims for services rendered to patients insured under Maricopa Foundation-endorsed plans.

308. On or about December 13, 1977, the Society's Board of Directors elected seven trustees to three-year terms on the Foundation's Board of Trustees.

The Maricopa Foundation only admits that in or about December 1977, its administrative members elected seven new trustees to the Maricopa Foundation's Board of Trustees.

309. The Society is an association of doctors in Maricopa County, Arizona.

The Maricopa Foundation has no information sufficient to admit or deny the truth or falsity of this statement and refers plaintiff to the response provided by the Maricopa County Medical Society.

310. The Foundation's participating members are doctors who are qualified to be or are active members of the Society or another county medical society in the State of Arizona or the Arizona Osteopathic Society.

The Maricopa Foundation only admits that to qualify as a participating member of the Maricopa Foundation, a physician must be licensed to practice medicine or osteopathy in Arizona.

311. The Foundation's cooperating members are members of the Arizona Podiatry Society or the Arizona Society of Oral Surgeons.

The Maricopa Foundation only admits that to qualify as a cooperating member of the Maricopa Foundation, a doctor must be licensed to practice podiatry or oral surgery in Arizona.

312. The Foundation's PSRO members are providers of medical services to Federal Medicare patients.

Denied. The Maricopa Foundation has no such member classification. *See* the By-Laws of the Maricopa Foundation revised as of August 14, 1977 produced to plaintiff on April 7, 1978.

313. Over 70 per cent of the doctors practicing in Maricopa County are Foundation members.

The Maricopa Foundation is without knowledge or information sufficient to admit or deny the truth or falsity of this statement with respect to the number of doctors who are practicing in Maricopa County, Arizona.

314. The Executive Director of the Society is also the Executive Director of the Foundation.

Admit.

315. The principal place of business of the Foundation and principal place of business of the Society are located in the same building.

Admit only that Maricopa Foundation and Maricopa Society have separate offices which are their separate principal places of business and that both are located in the same complex of offices.

* * * *

(Signature omitted in printing.)

EXHIBIT C

(Caption omitted in printing.)

DEFENDANT MARICOPA COUNTY MEDICAL SOCIETY'S RESPONSES TO PLAINTIFF'S FIRST REQUEST FOR ADMISSIONS AND INTERROGATORIES

* * * *

2. The members' of the Board of Directors of the Society are elected by the members of the Society.

ANSWER: Admit

3. The Members of the Board of Directors of the Society automatically become administrative members of the Foundation.

ANSWER: Admit

4. Administrative members are the only class of members in the Foundation having a general voting power.

ANSWER: N.A.

5. As the administrative members of the Foundation, the members of the Board of Directors of the Society elect or appoint the members of the Board of Trustees of the Foundation.

ANSWER: Admit

* * * *

308. On or about December 13, 1977, the Society's Board of Directors elected seven trustees to three-year terms on the Foundation's Board of Trustees.

ANSWER: Admit

309. The Society is an association of doctors in Maricopa County, Arizona.

ANSWER: The Maricopa Society admits only that it is a non-profit corporation whose members are licensed physicians.

* * * *

314. The Executive Director of the Society is also the Executive Director of the Foundation.

ANSWER: Admit

315. The principal place of business of the Foundation and principal place of business of the Society are located in the same building.

ANSWER: Admit

* * * *

(Signatures omitted in printing.)

EXHIBIT D

[Attorney Correspondence and Stipulations with Respect to Exhibits]

(Contents omitted in printing.)

EXHIBIT E

Maricopa Foundation for Medical Care 1970 [containing California Relative Value Studies]

(Contents omitted in printing.)

EXHIBIT F

Radiology Relative Values

(Contents omitted in printing.)

EXHIBIT G

American Society of Anesthesiologists, Relative Value Guide 1973

(Contents omitted in printing.)

EXHIBIT H

California Relative Value Schedule Conversion Manual 1974-1969-1964

(Contents omitted in printing.)

EXHIBIT I

Maricopa Foundation for Medical Care Conversion Factors for all New or Renewed Groups after December 1, 1977

(Contents omitted in printing.)